EFFECTS OF REALIGNMENT ON THE DELIVERY OF MENTAL HEALTH SERVICES

Prepared by the
CALIFORNIA MENTAL HEALTH PLANNING COUNCIL

JANUARY 1995

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We are indebted to staff at the State Department of Mental Health who provided us with fiscal data and data from the Client Data System. Staff were very generous with their time and expertise and very helpful in interpreting the information they provided.

We would also like to thank representatives from the mental health constituency whom we consulted in developing the scope of the study, designing the survey instruments, and interpreting the results. They provided valuable insights into realignment and its effects. We appreciate the assistance of the Institute for Mental Health Services Research with whom we co-sponsored the Town Hall Meeting on Program Realignment. The Institute put a great deal of effort into the conceptual development of the meeting and did an excellent job producing a summary of the proceedings.

TABLE OF CONTENTS

TABLE OF FIGURES AND TABLES

EXECUTIVE SUMMARY

CHAPTER 1: INTRODUCTION

Realignment, which refers to realigning the state and local relationships regarding the funding and primary programmatic responsibility of various health and human services programs, was enacted by Chapter 89, Statutes of 1991. It replaced over $700 million in funds from the General Fund with dedicated revenue from an increase in the sales tax and vehicle license fees. Realignment reorganized authority and control over resources in the mental health system, creating a single system of care at the county level and giving counties control over all their resources. In addition, key elements of system reform recommended in the *California Mental Health Master Plan* were implemented by the realignment legislation. Changes were also made to state and local advisory groups.

The California Mental Health Planning Council (CMHPC) was required by Section 5772(1) of the Welfare and Institutions Code to assess the effects of realignment on the delivery of mental health services. The CMHPC designed a study to address all the major aspects of realignment, obtaining data from statewide data systems; surveys of local mental health directors, mental health boards and commissions (MHB/Cs), and county supervisors; and public hearings and workshops. Because of the very high response rates to the surveys, the CMHPC believes that this report is very representative of the effects of realignment throughout the State.

CHAPTER 2: EFFECTS OF REALIGNMENT ON FUNDING FOR THE MENTAL HEALTH SYSTEM

Summary

Since deinstitutionalization and the advent of the community mental health system, local mental health programs have struggled to obtain funding sufficient to meet the demand for their services. After years of losing ground, local mental health programs chose to support the realignment proposal resulting from the state budget crisis of FY 1990-91.

At the state level, realignment was supposed to stabilize funding for the mental health system. Many factors have caused increases and decreases to mental health funding over the past decade. Just examining funding levels before and after realignment does not clearly reveal whether realignment has stabilized funding. However, the structural change in revenue sources that provided dedicated funding for mental health services and the elimination of competition with entitlement programs in the State General Fund has improved the stability of funding.

Realignment was also supposed to provide for predictable growth in revenue. This goal has not been achieved due to the recession that began in California the year realignment went into effect. The revenue shortfall amounted to $81 million in FY 1991-92. Although a significant increase in Short-Doyle/Medi-Cal reimbursements partially offset that loss, it was still a major blow to local mental health programs. Since that first year, realignment revenue for mental health services grew by approximately 6 percent in FY 1992-93 and did not grow significantly in FY 1993-94. That lack of growth is attributable to a provision that went into effect in FY 1993-94 giving first priority for growth funds to the Caseload Subaccount, which primarily funds growth in the case load of social services programs.

Local revenues have also been affected since realignment. Statewide, the mental health system has benefited from the subaccount transfer provision of realignment with more funds being transferred into mental health subaccounts than transferred out each year. Admittedly, this benefit to the system as a whole is no comfort to those local mental health programs in the Central Valley that have experienced net reductions due to transfers. These transfers are mostly attributable to counties'

needing more funds for entitlement programs. Transfers into mental health subaccounts are mostly to fund interagency agreements.

Although not a result of realignment per se, local overmatch has decreased since the implementation of realignment. Overmatch peaked in FY 1990-91 in response to significant reductions in funding at the state level. However, since FY 1992-93 counties have reduced their overmatch due in part to the State's actions in dealing with its own budget crisis. Diversion of counties' property tax revenue to fund education affected their ability to fund other local services.

On the whole, the funding structure of realignment has potential for improving the revenue picture for local mental health programs. The onset of California's recession clouds the picture, however. The mental health system should reevaluate the funding provisions of realignment after California has experienced several years of economic growth.

Chapter 2 contains the following findings and recommendations:

Effects of Realignment on State-level Revenues for Mental Health Services

Realignment stabilized funding for the mental health system.

Realignment affected the growth rates in funding for community programs and state hospitals.

Realignment has not yet provided predictable growth for mental health funds.

Recommendation

The mental health system should continue to monitor the effect on funding at both the state and local levels of having the sales tax and vehicle license fees as its revenue source. In addition, as the economy continues to recover, the mental health system needs to evaluate whether the structure of realignment growth accounts is producing equitable funding for mental health services.

Significant increases in Short-Doyle/Medi-Cal reimbursements cushioned the shortfall in realignment revenues.

Effects on Local-level Revenues for Mental Health Services

Subaccount Transfer Provision

Generally, mental health subaccounts have benefited from the provision to transfer funds among the subaccounts.

Role of Overmatch in Funding the Mental Health System

Local overmatch has decreased since realignment.

Recommendation

The mental health system should evaluate periodically the impact of state budget decisions on local-level funding for mental health services.

CHAPTER 3: PERFORMANCE OUTCOME MEASURES AS A TOOL FOR ACCOUNTABILITY

Summary

Performance outcome measures were established in statute as a counterbalance to the greater flexibility and autonomy provided to local mental health departments. Their purpose is to provide a mechanism for holding the mental health system accountable and to gauge the system's progress toward accomplishing system reform. Because of the complexity of the project and lack of precedence, developing performance outcome measures and data collection instruments has been a lengthy process. The mental health constituency also decided not to use the data until two waves of data from the adult instrument were available. As a result, performance outcome measures have not yet begun to function as a source of accountability.

In preparation for using the first two waves of data, which should be available early in 1995, stakeholders can take many steps that will improve the project. Disagreements have arisen between the various stakeholders in the project over aspects of implementation. Because the Performance Outcome Committee established in statute no longer exists, stakeholders do not have a forum to resolve their differences. The CMHPC should convene a joint decision-making group to serve this purpose. In addition, the CMHPC should begin to develop a closer working relationship with MHB/Cs, including developing a reporting format they can use to provide information to the CMHPC that aids in interpreting the data.

The DMH can advance the implementation of the project by providing technical assistance to stakeholders in the analysis and interpretation of the data, including descriptions of the statistical concepts involved. The DMH should also provide a context for interpreting the data, such as the prevalence of mental illness in each county and various demographic and socio-economic data. Moreover, so that all components of the mental health system are subject to the accountability envisioned in realignment, the DMH should develop performance outcome measures for state hospitals as required by statute.

More local mental health departments and MHB/Cs should also take steps to prepare for the use of performance outcome data. Although local mental health departments have generally made plans for integrating performance outcome measures into their quality management systems, they should increase their efforts to educate MHB/Cs on the project. Similarly, MHB/Cs need to take greater responsibility for obtaining the information they need on the purpose of performance outcome measures, what their role is in providing accountability on the local level, and how to interpret the data.

A very encouraging finding is that county supervisors who are aware of the performance outcome measures project believe the measures will improve local policymaking. However, more local mental health departments and MHB/Cs need to educate county supervisors about performance outcome measures because over a third of the supervisors responding to the survey were not aware of the project.

Chapter 3 contains the following findings and recommendations:

Assessment of the Process for Establishing Policies and Procedures for Collecting Performance Outcome Data

Finding **Page 19**

The project for developing performance outcome measures lacks a forum where stakeholders can formulate mutually acceptable policies for implementing the project.

Recommendation

The California Mental Health Planning Council should convene and provide support to a group of key stakeholders involved in implementing this project. This group shall provide leadership by developing policy and resolving conflicts among stakeholders on issues related to the performance outcome project. This group should be patterned after the Statewide Training Plan Committee established to implement the joint decision-making process in WIC Section 4061.

Assessment of the Implementation of Performance Outcome Measures

Department of Mental Health

Finding **Page 23**

The DMH needs to provide technical assistance in the analysis and interpretation of performance outcome data to the CMHPC, local mental health departments, and MHB/Cs.

Recommendation

- The DMH should develop a preface to accompany every discussion of performance outcome data that reviews the statistical concepts of sampling methodology, validity, and reliability. This preface should include how these methods were applied to the performance outcome data collection techniques, including the process of field testing.
- The DMH should provide a monograph or other document with sufficient information to enable the mental health scientific community to assess the methodology, the data, and their limitations.
- The DMH should make relevant information available to the CMHPC and to all counties to assist in the interpretation of data, including as a minimum:
    1. the Meinhardt prevalence study in a summarized, user-friendly format;
    2. other demographic data available from state sources, such as age distributions, ethnic composition, and poverty levels; and
    3. all performance outcome data so each county can do its own data analysis.

Finding **Page 24**

The DMH has not complied with the requirement to develop performance outcome measures for state hospitals.

Recommendation

The DMH should comply with its statutory mandate to develop performance outcome measures for state hospitals as soon as possible.

California Mental Health Planning Council

Finding **Page 24**

The CMHPC has not yet used the performance outcome data for system oversight and accountability.

Recommendation

The CMHPC should develop plans as soon as possible for using the performance outcome data, including developing a reporting format for the MHB/Cs to use in reporting their counties' findings to the CMHPC.

County Government

Mental Health Boards/Commissions

Finding **Page 25**

MHB/Cs have not yet begun to work with performance outcome measures.

Recommendation

- The DMH, in conjunction with the CMHPC, should provide annual training on performance outcome measures to the MHB/Cs and other interested parties.
- The CMHPC should prepare an informational pamphlet appropriate to all stakeholders providing background on the project and guidance in interpreting performance outcome data.
- The CMHPC should provide more direction and leadership to the MHB/Cs in performance outcome measures.

Local Mental Health Departments

Finding **Page 27**

Local mental health departments should increase their efforts to educate MHB/Cs on how to use performance outcome data.

Recommendation

All local mental health departments should make an effort to educate and include the MHB/Cs in all aspects of the performance outcome process.

Finding **Page 29**

Although local mental health departments have planned various means to integrate performance outcome data into their quality management systems, few are planning to share the results with the clients who provided the data.

Recommendation

- Local mental health departments should involve clients who provided the data on performance outcome measures to ensure their systems are client-driven and to obtain useful insights into their service systems.
- MHB/Cs should review the progress of local mental health departments in integrating performance outcome measures into the quality management systems.

Governing bodies

Finding **Page 31**

Most county supervisors surveyed have received information about performance outcome measures and believe the outcome measures will improve local policymaking.

Recommendation

Local mental health departments and MHB/Cs that have not emphasized educating governing boards about performance outcome measures should do so.

CHAPTER 4: EFFECTS OF REALIGNMENT ON GOVERNANCE STRUCTURES AT THE LOCAL LEVEL

Summary

One of the goals of realignment was to transfer the locus of funding, planning, and priority setting for mental health services to the local level. Local mental health departments and governing bodies were given more autonomy and flexibility so they could use their resources to meet the unique needs of their communities. This study indicates that most local mental health departments have manifested these goals of realignment by doing planning for their systems of care and by involving the major stakeholders in local mental health programs. In addition, some governing bodies are becoming more involved in mental health decision making as evidenced by their asking more questions about mental health budget issues at board meetings and participating more with their MHB/Cs.

Although realignment's goals of greater control and involvement in decision-making have been partially achieved by local mental health departments and governing bodies, MHB/Cs have had only limited success. The composition and process for appointing MHB/Cs were changed specifically to increase the involvement of direct consumers and family members in the decision-making process and to strengthen the relationship between county supervisors and their appointees. Achieving this goal is being undermined by lack of compliance with the statutory provisions. For example, nearly one-half of MHB/Cs have not had enough direct consumers and family members appointed. In addition, governing bodies are not making appointments that reflect the ethnic diversity of their communities, thereby reducing opportunities for input on the cultural competency of mental health services. Finally, two-thirds of the MHB/Cs have not been appointed according to the process outlined in statute whereby each county supervisor makes an equal number of appointments.

These problems with statutory compliance no doubt compound the difficulties MHB/Cs have in effectively performing their statutory duties. This study reveals that in the majority of counties MHB/Cs have not increased their input on mental health issues to either local mental health departments or governing bodies. Both MHB/Cs and local mental health departments have a clear sense of what factors contribute to the effectiveness and ineffectiveness of MHB/Cs and how to remedy the situation. A consistent source of training and technical support is called for. However, the entities at the state level that could provide such assistance have not done so largely because none have sufficient resources to accomplish the task. The CMHPC should convene a meeting of the parties involved to develop solutions to this problem.

Chapter 4 contains the following findings and recommendations:

Local Mental Health Departments

Finding _____ Page 33

Local mental health departments have done planning for their systems of care.

Finding _____ Page 34

Local mental health departments are not involving enough public agencies in their planning for adult systems of care.

Recommendation

When planning for adult systems of care, local mental health departments should involve all federal, state, and county agencies necessary to develop a comprehensive system of care. Many opportunities present themselves:

- county health departments for the implementation of managed care;
- Department of Rehabilitation district offices to increase opportunities for employment;
- Social Security Administration Offices to improve access to benefits for clients;
- community colleges to increase supported education programs;
- local housing authorities to increase the supply of affordable housing; and
- alcohol and drug programs for services to clients with dual diagnoses.

Governing Bodies

Finding **Page 38**

Some governing bodies are becoming more involved in mental health decision making.

Mental Health Boards/Commissions

Implementation of Statutory Requirements for the Composition and Appointment of Mental Health Boards/Commissions

Establishing a Mental Health Board or Commission

Finding **Page 41**

Nearly all counties surveyed had a MHB/C.

Recommendation

The DMH should contact the mental health director and the governing body for that county and urge compliance with the requirement that it have a MHB/C.

Finding **Page 41**

Most MHB/Cs are called boards.

Composition Requirements

County Supervisor as Member

Finding **Page 41**

Most MHB/Cs have a member of their governing body on their MHB/C.

Recommendation

In those counties that do not have a county supervisor on the MHB/C, the mental health directors and MHB/Cs in these counties should urge their governing bodies to comply with the requirement that their members serve on the MHB/Cs.

Direct Consumer and Family Member Representation

Finding **Page 43**

Almost one-half of MHB/Cs in large counties do not have sufficient representation of direct consumers and family members.

Recommendation

- Local mental health departments and MHB/Cs should provide more outreach to consumers, including training and leadership development, to help recruit more direct consumers for appointment to MHB/Cs.
- MHB/Cs and mental health directors should work with governing bodies to ensure they understand the statutory composition requirements and make appointments accordingly.

Finding _____ **Page 45**

Most MHB/Cs in small counties comply with composition requirements for direct consumers and family members. However, some small counties exceeding the 5-member minimum requirement do not comply with the composition requirement.

Recommendation

The statute should be amended to require that MHB/Cs in counties under 80,000 in population that choose to exceed the minimum size must comply with the composition requirements for large counties.

Ethnic Diversity of Appointments

Finding _____ **Page 47**

Most MHB/Cs do not reflect the ethnic diversity of their counties, especially for Latinos and Asians.

Recommendation

- Local mental health departments and MHB/Cs should conduct more focused recruitment, outreach, and leadership training to those ethnic groups under-represented on their MHB/Cs.
- Mental health directors and MHB/Cs should communicate with their governing bodies to emphasize the importance of making appointments that reflect the ethnic diversity of the community.

Appointment Process

Finding _____ **Page 48**

Only one-third of the counties use the correct appointment process.

Recommendation

Local mental health departments and MHB/Cs should remind their governing boards that the statute requires an equal number of appointments by each county supervisor.

Finding _____ **Page 52**

The statute is not clear concerning the size of MHB/Cs.

Recommendation

- The statute should be clarified to require that the representative from the governing body be in addition to the equal number of appointments made by each county supervisor to the MHB/C.
- Local mental health departments and MHB/Cs in those counties that are not complying with the appointment process and size requirements should encourage their governing bodies to appoint equal numbers of representatives.

Effectiveness of Mental Health Boards/Commissions in Performing Their Statutory Duties

Finding _____ **Page 53**

MHB/Cs are generally performing all the duties assigned to them in statute.

Finding _____ **Page 54**

Although MHB/Cs report performing their duties, their effectiveness is in question.

Recommendation

- Local mental health departments and MHB/Cs should conduct more focused recruitment, outreach, and leadership training to those ethnic groups under-represented on their MHB/Cs.
- Mental health directors and MHB/Cs should communicate with their governing bodies to emphasize the importance of making appointments that reflect the ethnic diversity of the community.

CHAPTER 5: IMPLEMENTATION OF SYSTEM REFORMS FROM THE *CALIFORNIA MENTAL HEALTH MASTER PLAN*

Summary

In the late 1980's and early 1990's, the process of developing the *California Mental Health Master Plan* was a crucible for reaching consensus about key aspects of system reform that were implemented in legislation enacting realignment. Now, in the mid-1990's, those principles have stood the test of time and are being used in the mental health system. For example, most local mental health departments have used the *Master Plan* when planning their systems of care. However, some local mental health departments chose not to use the *Master Plan*, and most MHB/Cs are unaware of it. No doubt, the lack of awareness by MHB/Cs results from most of their members being appointed in the past two years, well after the *Master Plan* was published. The CMHPC, which will be updating the *Master Plan* in 1995, should contact local mental health departments and MHB/Cs to determine how the Master Plan should be revised so it meets their needs.

One of the basic principles of the *Master Plan* was the need to develop a more client-driven system. This study found signs that the client-driven approach is beginning to be integrated into the mental health system. For example, local mental health departments have begun to involve direct consumers and family members in planning local programs. In addition, the number of direct consumers employed in local mental health programs has increased since the implementation of realignment.

However, the mental health constituency needs to do more to encourage the mental health system to embrace fully the client-driven philosophy. Needed steps include more regional empowerment workshops and training and leadership development for direct consumers and family members. To increase the employment of direct consumers, key stakeholders must develop an action plan that identifies barriers to increasing employment and provides solutions.

One of the accomplishments of the *Master Plan* was developing definitions for priority target populations, including children and youth, adults, and older adults. These definitions were enacted in the realignment legislation. However, the study found that the trend to shift services to priority target populations began before the implementation of realignment. From FY 1986-87 to FY 1992-93, the proportion of total clients served who met the definitions for target populations increased by 9.8 percent. However, most of that increase, 7.6 percent, occurred between FY 1986-87 and FY 1990-91, the period preceding implementation of realignment. The remaining 2.2 percent of that increase occurred after realignment was implemented.

Another central tenet of the *Master Plan* was providing mental health services in integrated systems of care. One of the most revolutionizing elements of realignment, converting state hospital and IMD bed allocations into fungible assets, stimulated the expansion of community-based systems of care. Local mental health departments to a very significant degree took advantage of this aspect of realignment by converting IMD and state hospital beds to funds. Although the hope was that these funds would be invested in systems of care, due to the shortfall in realignment revenues the first year of implementation, the preponderance of counties used these funds to offset a variety of revenue losses. However, in FY 1993-94 they began to use the funds to a greater extent to expand their systems of care.

This conversion of state hospital resources stimulated significant reform efforts in state hospitals. As a result of reducing the number of state hospital beds, rates began to rise because the hospitals' fixed costs had to be spread over fewer and fewer beds. The DMH developed lower cost programs that better met the needs of counties, and it significantly increased third-party revenues to reduce the portion of the costs that had to be charged to counties. In addition, the DMH, CMHDA, and other stakeholders have established a task force that is developing a strategic plan for long-term reform.

This study has revealed, however, that more needs to be done to meet the needs of small counties for access to long-term care resources. Revenue shortfalls have caused many small counties to drop out of the Small County State Hospital Bed Pool, leaving them at significant financial risk if even one of their clients requires placement in a state hospital.

In examining how local mental health departments used funds from converting state hospital and IMD resources, this study was not able to obtain sufficiently complete information concerning the quantity of services added or the actual dollar amounts invested. However, information is available concerning the types of services added and the number of counties that did so. Because most of the converted institutional beds had been occupied by adults, most of the services added in the community were for adults. Most of those services were for housing and residential treatment, case management, and intensive treatment teams.

No assessment has been completed of whether local mental health departments are developing their service systems consistent with the statutory guidelines and the principles contained in the *Master Plan*. In addition, this study found that emerging needs for programs serving clients with dual diagnoses and for clients who are incarcerated are not being developed to a significant degree. Consequently, the CMHPC should develop a means for determining whether local mental health departments are developing their systems of care in keeping with the *Master Plan*. The CMHPC should also determine how to stimulate the development of services for emerging unmet needs.

This study also focuses attention on the lack of priority being placed on the needs of older adults. The adult system of care continues to be expanded. The children's system of care, propelled by AB 377 and AB 3015, is expanding. However, the mental health system has not developed or tested a model system of care for older adults. The CMHPC should advocate for the development of such a model and for legislation to fund a pilot test.

The *Master Plan* also emphasized providing culturally competent services to mental health clients. Although the study was able to provide a profile of the ethnic groups in each region, it was not able to report on efforts to expand culturally competent services due to incomplete responses to the survey. Moreover, the mental health system has not conducted an assessment of the unmet need among ethnic minority groups for culturally competent services. The CMHPC should advocate for such a study as a necessary first step in improving the availability of culturally competent services.

Chapter 5 contains the following findings and recommendations:

Use of the *Master Plan*

Use by Local Mental Health Departments

Finding _____ **Page 67**

The preponderance of local mental health departments that did planning for their systems of care used the *California Mental Health Master Plan*.

Recommendation

Prior to revising the *Master Plan*, the CMHPC should contact local mental health departments that used the *Master Plan* to determine what aspects were the most useful. In addition, the CMHPC should make a special effort to contact local mental health departments that did not use the *Master Plan* to determine what prevented them from using it and what would make it more useful to them.

Use by Mental Health Boards/Commissions

Finding _____ **Page 68**

Most MHB/Cs are either unaware of the *Master Plan* or do not find it helpful to their planning efforts.

Recommendation

- The CMHPC should contact those MHB/Cs that did not find the *Master Plan* helpful to obtain their suggestions about how it should be modified to meet their needs.
- Prior to distributing the revised *Master Plan*, the CMHPC should provide training to all MHB/Cs to familiarize them with the *Master Plan*, its purpose, and the potential benefits of using it.

Client and Family Member Empowerment and Involvement

Involvement of Direct Consumers and Family Members in Policy Development

Finding _____ **Page 71**

Local mental health departments have begun to involve direct consumers and family members in planning for local mental health programs.

Recommendation

- The Statewide Training Plan Committee should include another round of empowerment workshops in a future training plan. These workshops should build on the previous empowerment workshops and focus on the benefits of collaboration. The target audience would be all groups party to the collaboration: local mental health departments, MHB/Cs, direct consumers, and family members.
- Focused training should be provided to direct consumers and family members in each county to enable them to be effective participants in department committees and task forces. This training should provide information about how local mental health departments operate, including budgeting and planning. Such training should help direct consumers and family members be effective advocates so that local mental health departments and governing bodies solicit their participation.

- To increase the pool of direct consumers available to participate in local mental health policymaking, mental health programs should enlist the aid of clinical staff and discharge planners at mental health facilities. These staff could inform direct consumers about the local mental health department's interest in empowering consumers to be involved in policymaking and could inform them of any training and advocacy opportunities.
- The California Network of Mental Health Clients and the California Alliance for the Mentally Ill should educate their members on the advantages of direct participation in task forces and committees established by local mental health departments.
- CMHDA leadership should emphasize in its policies and model for its directors the importance of involving direct consumers and family members in policymaking. Possibly, a series of presentations at its statewide meetings showcasing local mental health departments whose programs have benefited from collaboration among the departments, direct consumers, and family members would foster more inclusive decision-making methods.
- The CMHPC should also include presentations on empowerment and collaboration at its statewide meetings.

Employment of Direct Consumers and Family Members

Direct Consumers

Finding **Page 75**

Although local mental health programs have posted significant percentage increases in employment of direct consumers, the total number of direct consumers employed remains small.

Recommendation

- The DMH, CMHPC, CMHDA, and other key stakeholders should develop an action plan to increase the employment of direct consumers in mental health programs. The action plan should describe the full range of roles for direct consumers as professionals and paraprofessionals in local mental health programs. In addition, the action plan should evaluate whether barriers exist in county-operated programs and contract agencies to hiring direct consumers and should develop recommendations to eliminate those barriers. It should also examine the potential of the Rehabilitation Option to increase employment of direct consumers.
- The California Network of Mental Health Clients should organize direct consumers working for mental health programs, catalogue the achievements and contributions of these staff, and use this information to promote hiring greater numbers of direct consumers.

Family Members

Finding **Page 79**

Very few local mental health departments have established goals for hiring family members.

Availability of Self-help Services

Finding **Page 81**

The availability of self-help programs has increased in over 40 percent of local mental health programs.

Priority Target Populations

Finding **Page 81**

The proportion of clients who meet the definitions for target populations served by local mental health programs increased more prior to the implementation of realignment than it did afterwards.

Providing Services in Systems of Care

Conversion of IMD and State Hospital Resources

Finding **Page 86**

The resource flexibility provisions of realignment enabled local mental health departments to convert their state hospital and IMD resources into uses that better meet local needs.

Effect of Resource Flexibility on State Hospitals

Finding **Page 91**

Reduction in the number of state hospital beds for which counties contracted stimulated state hospital reform.

Finding **Page 92**

The DMH may need to take additional steps to meet the needs of small counties for access to state hospitals.

Recommendation

The DMH and the CMHDA should collaborate to examine the risk to small counties from not participating in the Small County Bed Pool. In addition, they should explore options for providing small counties with affordable methods of accessing long-term care services, such as developing a Fee-for-Service method enabling small counties to contract for very limited usage of state hospital beds and exploring the feasibility of regional long-term care services.

Use of Resource Flexibility To Expand Systems of Care

Finding **Page 94**

Local mental health departments used the resource flexibility provided by realignment to augment their community-based systems of care.

Recommendation

- The CMHPC should develop a means for determining whether local mental health departments are redesigning their systems of care consistent with principles and guidelines contained in the Master Plan and statutory provisions on minimum arrays of services for each target population.
- In its revision of the *Master Plan,* the CMHPC should strive to discover ways of encouraging state and local budget and policy decisions that develop programs responding to unmet needs in the mental health system, such as services for clients with dual diagnoses and for clients who become incarcerated.

Finding **Page 97**

In expanding their systems of care, local mental health departments focused primarily on their systems of care for adults.

Recommendation

The mental health system needs to focus on expanding the systems of care for children and older adults by taking the following steps:

- continue to find additional funding for increasing the number of counties able to implement the children's system of care;
- develop a model system of care for older adults; and
- enact legislation with adequate funding to conduct a pilot test of the effectiveness of the model system of care for older adults.

Providing Culturally Competent Services

Finding **Page 99**

Further study is need to determine whether local mental health programs are making efforts to increase the cultural competency of services.

Recommendation

The California Mental Health Planning Council should work with the DMH and other stakeholders to plan an assessment of the needs of ethnic minorities for mental health services. This study should also determine the extent to which local mental health programs are meeting those needs and develop an action plan for reducing unmet need.

CHAPTER 6: OVERALL EFFECTS OF REALIGNMENT

Summary

Local mental health departments, governing bodies, and MHB/Cs all rate realignment as "somewhat positive." Paradoxically, the most frequently identified positive effects of realignment are all contradicted by the most frequently identified negative effects. This situation reflects the complexities of realignment and the economic and political environment in which the mental health system operates. Consequently, people have beliefs about realignment and its effects that on the surface appear inconsistent. For example, mental health directors and MHB/C members identified as one of the most positive effects that realignment switched the revenue source for mental health to the sales tax, which they believe is a stable source of funding with potential for growth. At the same time, these respondents identified the most negative effect of realignment to be the sales tax shortfall resulting from the economic recession that California has been experiencing.

These contradictory beliefs can be reconciled by understanding that some result from taking the long view of the potential benefits of realignment and some result from evaluating the short-term consequences. In the long run, the mental health system is probably better off with a dedicated funding source that insulates it from competition with entitlement programs in the General Fund. In the short run, enacting realignment, which used a revenue source sensitive to the health of the economy, just as a recession was hitting California had very negative consequences for mental health programs that had to reduce the services they provided.

Chapter 6 contains the following findings:

Overall Ratings

Finding **Page 105**

Local mental health departments, governing bodies, and MHB/Cs rate the overall effects of realignment as "somewhat positive."

Positive and Negative Effects

Finding _____Page 106

Local mental health departments and the MHB/Cs were fairly close in their assessments of the positive and negative effects of realignment.

CHAPTER 1

INTRODUCTION

Elements of Realignment

Changes in Funding

Realignment, which refers to realigning the state/local relationship regarding the funding and primary programmatic responsibility of various health and human services programs, was enacted by Chapter 89, Statutes of 1991. It grew out of the fiscal crisis that the State faced in fiscal year (FY) 1990-91 when the projected deficit for the coming year reach $14 billion. The State was interested in finding an alternate funding source for some of its programs and moving them out of the General Fund to reduce the deficit. County governments were interested in realigning the state/local relationship to give counties more control over funding and program design. Mental health advocates wanted to escape the budget disaster that awaited them from the deficit in the General Fund. In addition, advocates had been working on a variety of system reform proposals, and they viewed the realignment legislation as an opportunity to implement those reforms.

As a result of this confluence of interests, all parties were able to reach consensus on the provisions of realignment. In addition to affecting mental health programs, this proposal also realigned health and social services programs. Realignment is funded by a one-half cent increase in the sales tax and by an increase in vehicle license fees. This funding replaced over $700 million in funds from the General Fund that had been appropriated for mental health services.

Realignment revenues are collected by the State and placed in various accounts and subaccounts in the Local Revenue Fund. The funds are then distributed to the counties and deposited in local health and welfare trust funds. The local trust fund is composed of subaccounts for mental health, health, and social services. The statute defines what these funds may be used for and prohibits all other uses. This dedicated funding feature was particularly appealing to mental health advocates, who for years watched other programs in the General Fund receive increases at the expense of mental health funding.

Realignment reorganized authority and control over resources in the mental health system, creating a single system of care at the county level and giving counties control over all their resources. Allocations of state hospital beds and Institutions for Mental Disease beds were converted into funds that counties could spend as they saw fit. Burdensome reporting requirements, such as the county plan, were replaced with performance contracts that counties enter into with the DMH annually.

Key elements of system reform were also implemented by realignment. It established a mission for California's mental health system based on the client-centered approach to providing mental health services. The statute also established definitions for priority target populations to help focus how resources are spent. Another essential aspect of realignment was providing for accountability in the mental health system. This goal was accomplished by requiring the State Department of Mental Health (DMH) to develop performance outcome measures, which would provide data measuring whether mental health services improved the quality of clients' lives.

In 1993 modifications had to be made to some of the funding provisions of realignment. Chapter 100, Statutes of 1993, made major changes focusing on the distribution of realignment growth funds, which are defined as revenue that exceeds the amount distributed in FY 1991-92. The measure clarified that the first priority for the use of growth monies is the funding of increased caseload in various social services programs and the California Children's Services program. It also established

a new Base Restoration Subaccount with funds dedicated to restoring each county to the level of funding originally projected to be available in FY 1991-92.

Changes to the Governance Structures

Department of Mental Health (DMH)

Because of the authority for operating mental health programs that was transferred to local mental health departments, the DMH underwent a change in its mission. The California Mental Health Planning Council (CMHPC) commissioned a study to identify the appropriate governance structure for the mental health system in light of changes brought about by realignment. This study concluded that realignment did not eliminate the need for a state-level mental health entity. It identified critically important functions for which the DMH is responsible. These functions relate primarily to leadership and enabling and supporting local governments and others to provide necessary mental health services. Realignment changed the roles and responsibilities assigned to the state level. However, important and numerous tasks remain that need to be performed by a state entity, including administration of federal funds; system oversight, evaluation, and monitoring; direct services; and administrative support. Based on the results of this study, the DMH restructured its operations and priorities.

State and Local Advisory Groups

Because of the fundamental changes in program authority and responsibility made by realignment, the statute required that the DMH, in consultation with relevant organizations, review the purpose and function of state and local advisory groups and recommend an appropriate structure for public input, planning, and evaluation under realigned mental health programs. As a result of this review, Chapter 1374, Statutes of 1992, eliminated three state-level organizations: the California Council on Mental Health, the Conference of Local Mental Health Directors, and the Organization of Mental Health Advisory Boards. It also added to state law the California Mental Health Planning Council. This group existed previously as the PL 99-660 Planning Council, which is required by federal law as a condition for receiving the federal mental health block grant. This group's federal duties were included in state law along with additional duties given to it appropriate to the needs of the realigned mental health system.

The statute also made changes to provisions governing local mental health advisory boards. Their name was changed to "mental health board or commission" (MHB/C). Their duties were modified to be consistent with other changes made by realignment. Realignment transferred much of the authority for planning and funding mental health services to the local level, giving county governing bodies much greater control of local mental health programs. Because of this heightened role, having a close working relationship between governing bodies and MHB/Cs became even more important. Consequently, the statute changed the composition and appointment process for the boards in an effort to strengthen the communication between county supervisors and their appointees.

Methodology of Study

The CMHPC was required by Section 5772(l) of the Welfare and Institutions Code (WIC) to assess the effects of realignment on the delivery of mental health services. The CMHPC designed a study to address all the major aspects of realignment, including changing the source of revenue, creating performance outcome measures, providing greater autonomy and flexibility to local mental health programs, changing the provisions governing mental health boards and commissions, and implementing recommendations for system reform from the *California Mental Health Master Plan*.

Surveys for Collecting Data

Obtaining a comprehensive picture of how realignment affected the delivery of mental health services required detailed information from the local level. Accordingly, the CMHPC developed three data collection instruments: one for local mental health departments, one for MHB/Cs, and one for the county supervisors appointed to serve on MHB/Cs. These instruments were field tested and then distributed to the appropriate entities in all counties.

Response rates to all three surveys were very high. Table 1 shows that 57 out of 59 local mental health departments responded to the survey. Table 2 reports that for MHB/Cs the response rate was not quite as high with 49 out of 59 MHB/Cs responding. Table 3 provides the response rate for county supervisors appointed to MHB/Cs. Responses were received from 42 out of 59 potential respondents. As a result of these response rates, the CMHPC believes that this report is very representative of the effects of realignment throughout the State.

Table 1: Local mental health departments responding to survey.

Region	Counties Responding to Survey	Number of Counties in State	Percent of Counties Responding to Survey
Bay Area	12	13	**92.3%**
Central	18	18	**100.0%**
Southern	11	11	**100.0%**
Superior	16	17	**94.1%**
Statewide	**57**	**59**	**96.6%**

Source: Survey of Local Mental Health Departments

Table 2: MHB/Cs responding to survey.

Region	Counties Responding to Survey	Number of Counties in State	Percent of Counties Responding to Survey
Bay Area	12	13	**92.3%**
Central	14	18	**77.8%**
Southern	10	11	**90.9%**
Superior	13	17	**76.5%**
Statewide	**49**	**59**	**83.1%**

Source: Survey of Mental Health Boards/Commissions

Table 3: County supervisors responding to survey.

Region	Counties Responding to Survey	Number of Counties in the State	Percent of Counties Responding to Survey
Bay Area	9	13	**69.2%**
Central	12	18	**66.7%**
Southern	9	11	**81.8%**
Superior	12	17	**70.6%**
Statewide	**42**	**59**	**71.2%**

Source: Survey of County Supervisors

Interpreting Tables Presenting Survey Results

Questions in the survey instruments for all three groups fall into two categories: questions that could have only one answer and questions that could have multiple responses. Tables presenting the results to questions with just one answer are very straightforward to interpret. For example, county supervisors provided just one response to describe the extent of their involvement with MHB/Cs. Table 17 on Page 40 presents these results. Each column lists by region the number of counties providing the various responses. For each region, the percentage of counties providing each answer is calculated by dividing the number of counties giving each response by the total number of counties responding.

Tables for questions with multiple responses are set up somewhat differently. Table 6 on Page 26 is an example of this type of question. Forty-eight MHB/Cs provided 104 responses describing their plans for working with performance outcome measures. For each region, columns present the number of counties providing each response. These columns are labeled "Number of Responses." The number of responses was divided by the number of counties in each region responding to the question to display what percentage of counties was planning to implement each action. This figure for the number of counties responding in each region is found in a one-line table underneath each multiple-response table. Because of the method used to calculate the percentages, each column sums to a number greater than 100 percent. For completeness, the table includes a "Grand Total" line summing the number of responses received in each region. However, it is not used in the analysis.

Public Hearings

In addition to collecting data with surveys, the CMHPC conducted six public hearings during 1994 to obtain information on the effects of realignment. These hearings were held in Los Angeles, San Francisco, Sacramento, San Diego, Fresno, and Redding. They provided a valuable perspective on realignment. Testimony from these hearings is used throughout the report to introduce various sections.

Workshops

To involve a representative cross-section of the mental health constituency in discussions concerning realignment, the CMHPC held two one-day workshops. In May 1994, the CMHPC co-sponsored a town hall meeting with the Institute for Mental Health Services Research. The Institute is a research group funded by the National Institute for Mental Health and affiliated with major universities in the Bay Area. It is also conducting an evaluation of realignment. Discussions from this town hall meeting proved to be very informative. Quotations from the report prepared by the Institute, which summarized the meeting, are also used to introduce sections of this report. In addition, once an initial draft of the report's findings and recommendations had been completed, the CMHPC held a one-day workshop for its members and other knowledgeable members of the mental health constituency to ensure that data was being interpreted correctly

CHAPTER 2

EFFECTS OF REALIGNMENT ON FUNDING FOR THE MENTAL HEALTH SYSTEM

Effects of Realignment on State-level Revenues for Mental Health Services

> *...county public mental health programs and clients...[have] been "saved" by Realignment; other county programs have suffered far worse budget cuts than mental health during the recent recession and budget crisis.*
>
> *...another positive result of realignment is that county mental health programs no longer need to put all their energies into lobbying Sacramento to obtain funding because sales tax dollars provide a guaranteed source of revenue. County mental health programs now have more time and energy to fight local cuts in services and to focus on internal management and change.*
>
> *Town Hall Meeting on Program Realignment*
> *San Francisco, CA, May 27, 1994*

Finding

Realignment stabilized funding for the mental health system.

Overview of Funding for the Mental Health System

Prior to 1957, most persons with mental illnesses requiring public mental health services were treated for lengthy periods in state hospitals. The move toward deinstitutionalization began in the late 1950's because of concern with conditions in these institutions and the hope that a community-based system would improve care. In addition, the development of psychotropic medications enabled many persons with serious mental illnesses to be treated in the community. The greatest reduction in the state hospital population occurred between 1957 and 1988 when it dropped from a high of 37,000 clients in 1957 to around 5,000 by 1988. (Elpers, 1989, p. 800)

Two changes in California law enabled deinstitutionalization to proceed. First, the Short/Doyle Act was passed in 1958. This Act set up a state administrative structure for local services. If counties chose to establish local mental health services, the State covered 50 percent of the costs. Subsequently, the State mandated that counties provide mental health services and assumed greater responsibility for funding those services by increasing the State's share of funding to 90 percent. By 1967, the number of state hospital beds had decreased to 25,000. (Elpers, p. 800) Adoption of the Lanterman-Petris-Short (LPS) Act in 1968 further reduced the population in the state hospitals. The LPS Act strengthened commitment laws by eliminating long-term, open-ended commitments. This Act enabled clients to live in the community with the support of community-based services and short-term hospitalization when necessary.

Despite the State's commitment to community-based mental health services in the statutes it adopted, the State did not follow through with adequate funding. From 1969 to 1973, the State did increase funding for the newly mandated local mental health programs. (Elpers, p. 801) However, policymakers failed to distribute to community programs much of the savings from state hospital closures and population reductions. Between 1975 and 1990, the mental health system experienced an erosion of approximately $320 million due to unfunded population growth and increases in the cost of living. (CMHDA, 1990, p. 2) For example, from 1974 to 1980 high inflation reduced per

capita funding for local mental health programs. While the Consumer Price Index rose more than 10 percent per year for a total increase of 54 percent, funding for local mental health programs increased by only 42 percent, producing a net reduction of 12 percent. (CCLMHD, 1988a) A surge in population compounded this problem. Between 1981 and 1987, California's population increased by 22 percent. (CCLMHD, 1988b, p. 3) However, the State did not increase funding to compensate for the increased need for mental health services produced by the population growth.

Many factors contributed to this underfunding. Other health and social service programs were established as entitlements. Increases in their case loads determined their funding. Mental health services, which were not established as an entitlement, could not successfully compete for funding. In addition, a constituency more powerful and organized than that for mental health advocated for these programs. (Elpers, 1989, pp. 802-803) To make matters worse, the passage of Proposition 13 in 1979 severely limited property tax revenues. (Elpers, 1989) This action restricted the counties' ability to generate local revenues to fund programs.

Besides the financial constraints mental health programs were experiencing, the mental health system was also disadvantaged by its governance structure. County governments had authority for operating the local mental health system while the State maintained funding authority. This arrangement created a split between funding and operating responsibility. As a result, the State had no real authority to direct local services. One impact of this decentralization was the perception by the Legislature that the problems were due to county mismanagement, excessive overhead, or misplaced priorities. (Elpers, 1989, pp. 803-804)

Another factor contributing to the inability to obtain adequate funding from the State was that the accomplishments of the mental health system were not being measured. This situation made it difficult to portray clearly to policymakers how the money was spent and the extent of unmet need. Local mental health programs provided a broad array of services with the resources provided. But, the State's data collection system did not produce information about what the mental health system accomplished with the funds. (Goodwin, 1993)

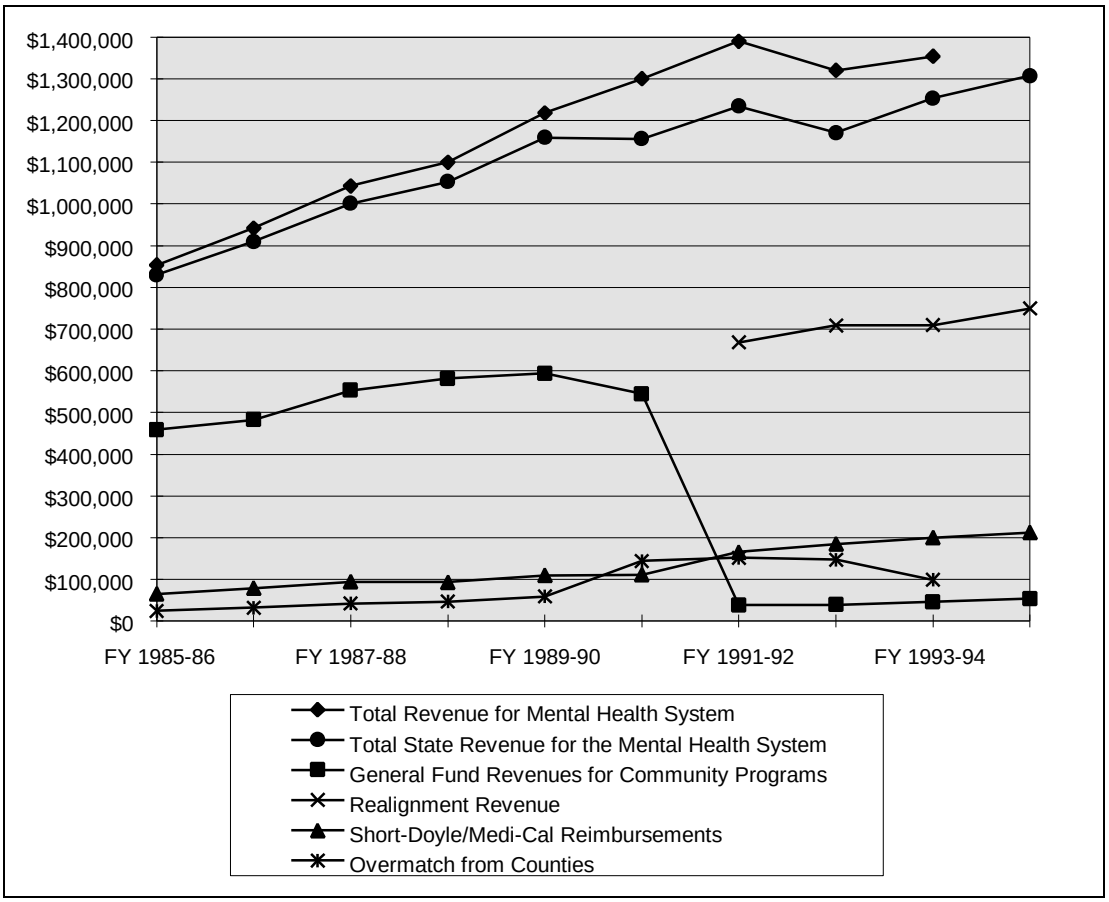
To help relieve the State's budget deficit, it began to cut the discretionary General Fund allocation to mental health. In FY 1988-89, the State had reached its constitutional spending limit. (Goodwin, 1993) In FY 1989-90, the State reduced mental health funding by approximately $49 million. By FY 1990-91, the State faced a $14.3 billion shortfall, portending disaster for mental health. (Goodwin, 1993) More and more persons with serious mental illnesses were not receiving services. Local mental health programs were forced to discharge clients earlier than clinically appropriate and also had to refuse treatment more often. Many persons were turned away or put on lengthy waiting lists. This lack of service manifested itself in a dramatic increase in persons with serious mental illnesses who were homeless and who were incarcerated. (California Coalition for Mental Health, 1991)

Effect of Realignment on Mental Health Funding

Realignment was a response to the preceding 20 years of chronic underfunding. One intention of realignment was to stabilize funding for the mental health system. Figure 1 provides ten years of data on funding, including total revenue from all sources, total state revenue for the mental health system, total revenue from the General Fund for community programs (referred to as Local Assistance prior to realignment), realignment revenue, Short-Doyle/Medi-Cal reimbursements, and overmatch by county governments.[1]

[1] Table 83 and Table 84 in Appendix 2 show the total revenue from the State for community programs and state hospitals and county revenues for mental health services from FY 1985-86 through FY 1994-95.

Figure 1: Funding for the mental health system from FY 1985-86 to FY 1994-95 (in thousands).



Source: State Department of Mental Health

Determining whether realignment stabilized funding is difficult because many independent factors have caused increases and decreases in funding over the years. For example, the gradual increase from FY 1985-86 to FY 1989-90 in General Fund revenues for community programs is actually rather deceptive. The preceding discussion has explained that rate of inflation and population growth outpaced the increase in funding for mental health services. In addition, the apparent increase in funding in FY 1987-88 resulted from a $53 million increase in General Fund revenues due to a change in the funding source for Institutions for Mental Disease (IMDs). The federal government disallowed using Medi-Cal to fund IMDs. As a result, the General Fund had to absorb the full cost. Although this infusion of funds increased the amount of General Fund revenue for mental health services, it did not increase the amount of services available in the community. Just as increases in funding can be deceptive, so can decreases. The lines on the graph in Figure 1 for Total Revenue and Total State Revenue show a decrease in FY 1992-93 primarily due to the loss of $40 million in Cigarette and Tobacco Tax revenue and not because of a decrease in realignment revenues.

Another indication of the complexity in evaluating the impact of realignment on funding is that county supervisors are divided on this question. Table 4 on Page 8 shows that 22 county supervisors, 52 percent, believe realignment stabilized funding and 18 county supervisors, 43 percent, believe realignment did not stabilize funding.

Table 4: Do county supervisors believe realignment stabilized funding?

	Yes		No		Do Not Know			
Region	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Total Number of Counties	Total Percent of Counties
Bay Area	4	44.4%	5	55.6%	0	0.0%	9	100.0%
Central	8	66.7%	4	33.3%	0	0.0%	12	100.0%
Southern	6	66.7%	3	33.3%	0	0.0%	9	100.0%
Superior	4	33.3%	6	50.0%	2	16.7%	12	100.0%
Statewide	**22**	**52.4%**	**18**	**42.9%**	**2**	**4.8%**	**42**	**100.0%**

Source: Survey of County Supervisors

County supervisors may not believe realignment stabilized funding because the revenues have never achieved the base amount of General Funds they were intended to replace. Many county supervisors may be hesitant to say realignment stabilized funding while California is still in a recession, which affects the amount of sales tax revenues collected. In addition, county supervisors may be looking at the broader picture of the realignment of mental health, social services, and health services and how this shift in funding has affected counties overall. County supervisors are probably aware of the tenuous nature of any dedicated funding, which can easily be changed by legislative action.

As the county supervisors' opinion of realignment indicates, separating the effects of the recession from the structural change in funding produced by realignment is difficult. In addition, the diverse factors contributing to the revenue picture for mental health at the state level over the past ten years also contribute to difficulty in reaching definitive conclusions about the effect of realignment on the stability of funding for mental health services. However, removing the mental health budget from the State General Fund has eliminated having to compete with entitlement programs for scarce dollars. That change alone can be credited with improving the stability of funding. Moreover, placing realignment revenue in dedicated trust funds also gives mental health funding more stability than it has ever had.

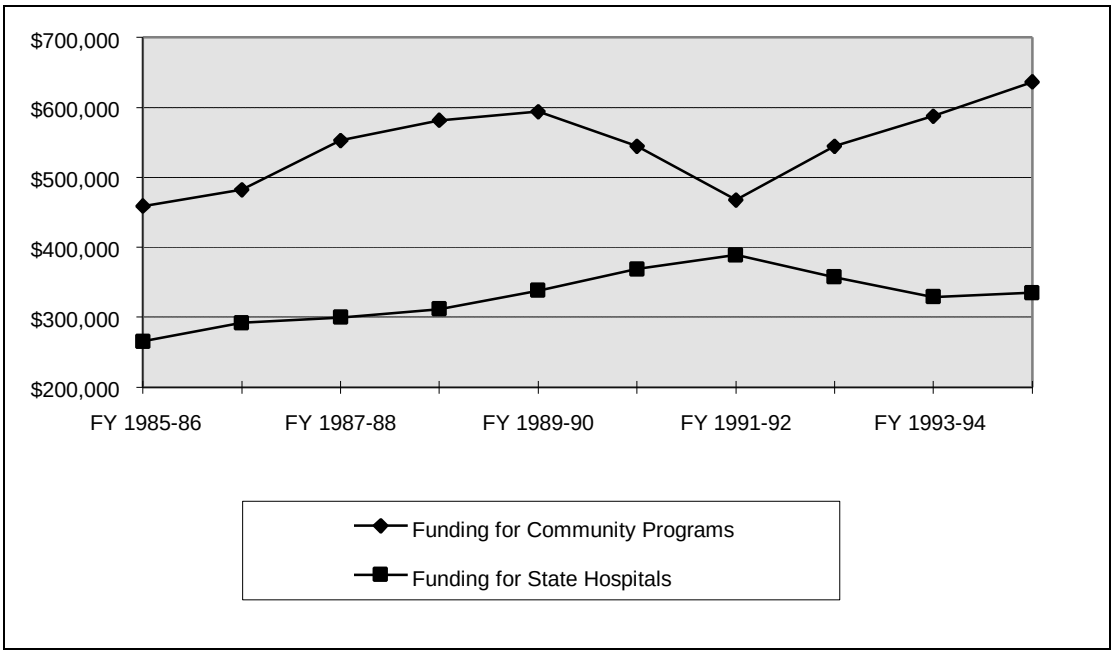
Finding

Realignment affected the growth rates in funding for community programs and state hospitals.

Figure 2 illustrates a concern that the mental health constituency had in the years leading up to realignment: while funding for community mental health programs was decreasing, funding for state hospitals was increasing. This trend is particularly noticeable from FY 1988-89 to FY 1991-92. While funding for community programs grew only slightly or actually decreased, funding for state hospitals continued to climb. The constituency believed this phenomenon resulted from the greater "ownership" the State had of state hospitals. The State was directly responsible for funding and operating state hospitals whereas community mental health services were operated by the counties.

With the implementation of realignment, the trend has reversed. Beginning in FY 1992-93 when the process for contracting for state hospital beds began, local mental health departments, which now control the amount of resources spent on state hospitals, have chosen to increase the proportion of resources they spend on community mental health programs and to reduce the proportion spent on state hospitals, as illustrated by Figure 2.

Figure 2: Comparison of funding for community programs and state hospitals--General Fund and realignment revenues (in thousands).



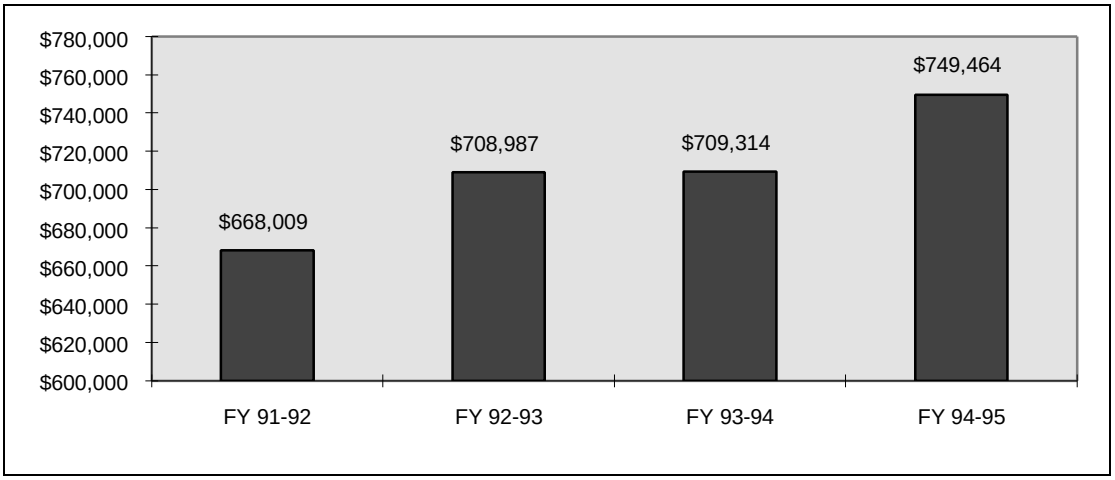
Source: State Department of Mental Health

Finding

Realignment has not yet provided predictable growth for mental health funds.

One goal of realignment was to provide for predictable growth in funding of approximately 6 to 8 percent annually. Figure 3 shows the local revenues for FY 1991-92 through FY 1994-95.

Figure 3: Realignment revenue (in thousands).

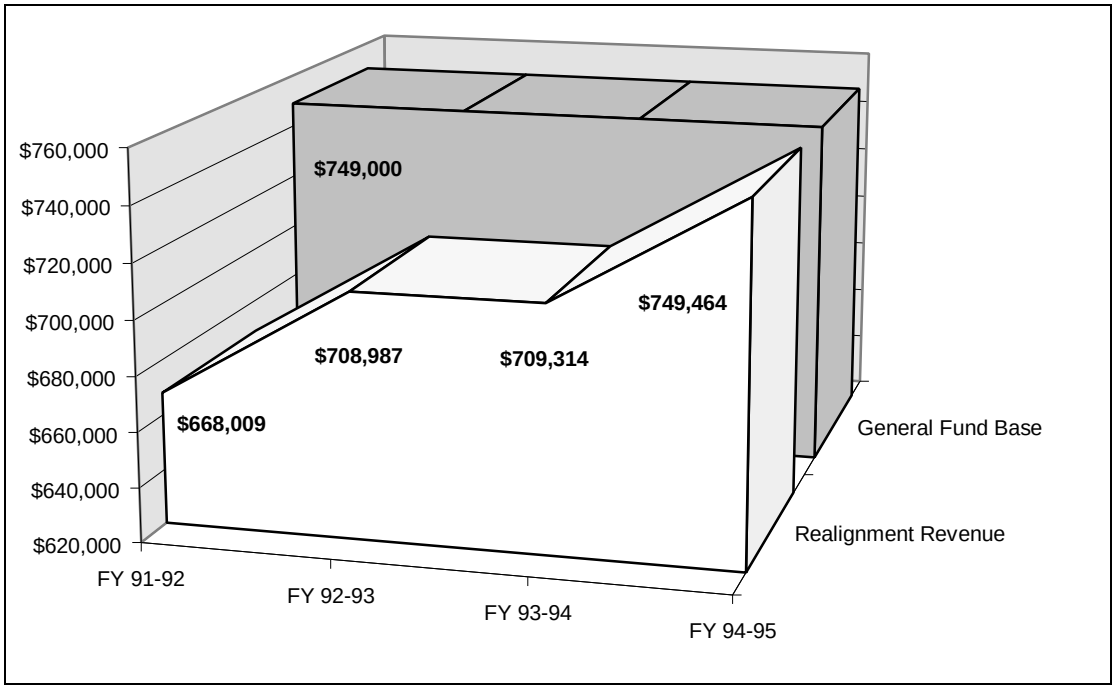


Source: State Department of Mental Health

The most harmful effect of realignment is illustrated in Figure 4 on Page 10 , which shows realignment revenue fell short by $81 million from the base of $749 million. This shortfall occurred because realignment coincided with California's recession. The sales tax revenues did not reach the base amount of funding that had been spent on mental health services in FY 1990-91. The shortfall

from the base was -10.8 percent during FY 1991-92, the first year of realignment. In FY 1992-93 and FY 1993-94, the shortfall from the base was decreased to -5.3 percent as sales tax revenue grew. The Department of Finance is projecting a growth from the base of 0.1 percent for FY 1994-95.

Figure 4: Shortfall of realignment revenues from the General Fund base (in thousands).

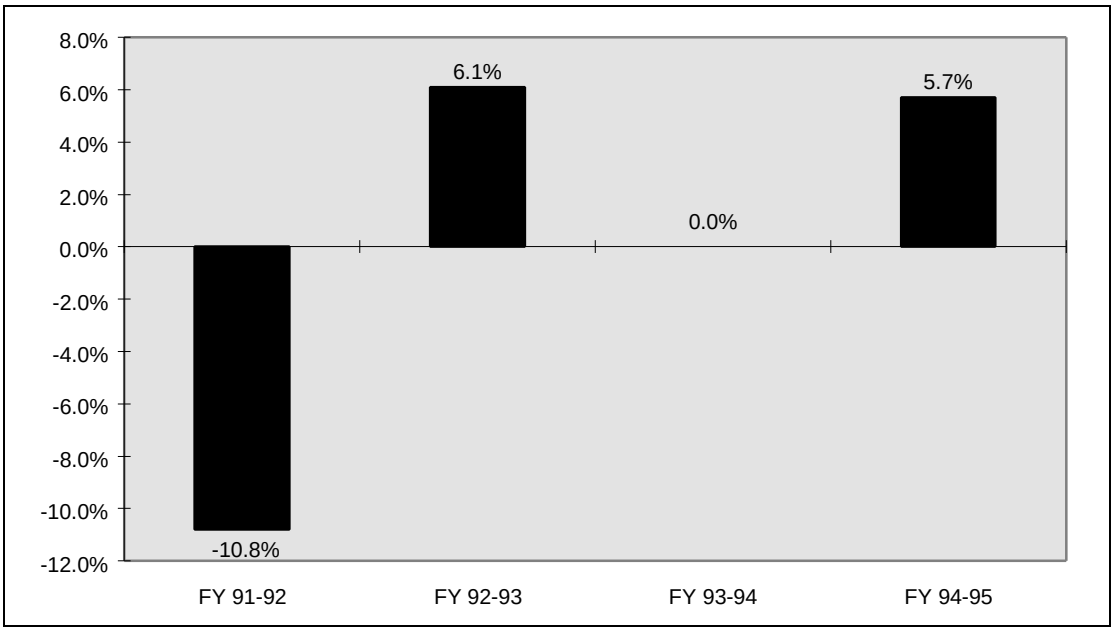


Source: State Department of Mental Health

The State's recession has slowed growth in sales tax revenues and created the initial shortfall. Nonetheless, realignment revenues are growing steadily. The percentage changes for the post-realignment years illustrated in Figure 5 show one year with a good increase of 6.1 percent, one year with scant growth, and for FY 1994-95, a projected increase.[2] However, each year the growth projections for realignment revenues made by the Department of Finance have not materialized. Thus, whether realignment revenue will actually grow almost 6 percent in FY 1994-95 as projected is uncertain. The mental health system needs to experience several more years with a stable state economy to determine conclusively if realignment provided for predictable growth in mental health funding.

[2] Table 85 in Appendix 2 provides the realignment revenues from FY 1991-92 through FY 1994-95 and reports changes in the shortfall and growth in revenue for each year.

Figure 5: Percentage change in realignment revenue.



Source: State Department of Mental Health

Provisions of Chapter 463, Statutes of 1993, contributed to the lack of growth for realignment revenue in FY 1993-94. This legislation significantly amended the statutes governing the distribution of realignment growth funds. It established that the first priority for growth monies is funding the increased case load primarily in various social services programs, such as AFDC. It also established a Base Restoration Account with funds dedicated to restoring each county to the level of funding originally projected to be available in FY 1991-92. Because of the case load growth in FY 1993-94, most of the growth in realignment revenues went to the Caseload Subaccount.

Recommendation

The mental health system should continue to monitor the effect on funding at both the state and local levels of having the sales tax and vehicle license fees as its revenue source. In addition, as the economy continues to recover, the mental health system needs to evaluate whether the structure of realignment growth accounts is producing equitable funding for mental health services.

Finding

Significant increases in Short-Doyle/Medi-Cal reimbursements cushioned the shortfall in realignment revenues.

In FY 1991-92, an increase of $55 million in Short-Doyle/Medi-Cal reimbursements substantially offset the $81 million shortfall in realignment revenue. Figure 1 on Page 7 reveals that since FY 1990-91 Short-Doyle/Medi-Cal reimbursements have increased by over $100 million. This increase results from several factors. First, local mental health departments have been very effective in qualifying eligible clients for Medi-Cal benefits. Second, in FY 1991-92 the State implemented the Targeted Case Management Medi-Cal Option, which increased the services that could generate Medi-Cal revenue. Finally, starting with FY 1993-94, the State implemented the Rehabilitation Option, which expanded even further the services eligible for Medi-Cal reimbursement.

Effects on Local-level Revenues for Mental Health Services

Subaccount Transfer Provision

Finding

Generally, mental health subaccounts have benefited from the provision to transfer funds among the subaccounts.

WIC Section 17600.20(a) authorizes any county or city to reallocate money among subaccounts not to exceed 10 percent of the amount deposited in the account from which the funds are reallocated for that fiscal year.[3] Table 5 summarizes the net subaccount transfers for each year of realignment. In the first year, net transfers totaled $4.7 million with no funds transferred out of mental health subaccounts. In FY 1992-93, net transfers in the mental health subaccounts totaled $2.5 million; and in FY 1993-94, $2.5 million.

Table 5: Net funds transferred in or out of Mental Health Subaccount in FY 1991-92, FY 1992-93 and FY 1993-94.

Region	FY 1991-92	FY 1992-93	FY 1993-94
Bay Area	$4,000,000	$4,200,000	$4,300,000
Central	$103,000	($2,405,000)	($3,358,000)
Southern	$459,000	$710,000	$1,583,000
Superior	$96,000	($26,000)	
Grand Total	**$4,658,000**	**$2,479,000**	**$2,525,000**

Source: State Controller and Survey of Local Mental Health Departments

Figure 6, Figure 7, and Figure 8 present by region the funds transferred in or out of the mental health subaccounts for FY 1991-92, FY 1992-93, and FY 1993-94, respectively. Local mental health departments in the Central region have been the most adversely affected by transfers out of their mental health subaccount with $2.4 million transferred out in FY 1992-93 and $3.4 million in FY 1993-94.

[3] Table 85 through Table 92 in Appendix 2 provide detailed information on the amounts and reasons for subaccount transfers by region.

Figure 6: Subaccount transfers by region for FY 1991-92.

Superior Region
Funds Transferred in: $96,000
Funds Transferred out: $0
Net Transfer: $96,000

Bay Area
Funds Transferred in: $4,000,000
Funds Transferred out: $0
Net Transfer: $4,000,000

Central Region
Funds Transferred in: $103,000
Funds Transferred out: $0
Net Transfer: $103,000

Southern Region
Funds Transferred in: $459,000
Funds Transferred out: $0
Net Transfer: $459,000

Statewide Total
Funds Transferred in: $4,658,000
Funds Transferred out: $0
Net Transfer: $4,658,000

Source: State Controller and Surveys of Local Mental Health Departments

Figure 7: Subaccount transfers by region for FY 1992-93.

Superior Region
Funds Transferred in: $40,000
Funds Transferred out: ($66,000)
Net Transfer: ($26,000)

Bay Area
Funds Transferred in: $4,200,000
Funds Transferred out: $0
Net Transfer: $4,200,000

Central Region
Funds Transferred in: $0
Funds Transferred out: ($2,405,000)
Net Transfer: ($4,205,000)

Southern Region
Funds Transferred in: $1,583,000
Funds Transferred out: $(873,000)
Net Transfer: $710,000

Statewide Total
Funds Transferred in: $5,823,000
Funds Transferred out: $(3,344,000)
Net Transfer: $2,479,000

Source: State Controller and Surveys of Local Mental Health Departments

Figure 8: Subaccount transfers by region for FY 1993-94.

Superior Region
Funds Transferred in: $0
Funds Transferred out: $0
Net Transfer: $0

Bay Area
Funds Transferred in: $4,300,000
Funds Transferred out: $0
Net Transfer: $4,300,000

Central Region
Funds Transferred in: $0
Funds Transferred out: $(3,358,000)
Net Transfer: $(3,358,000

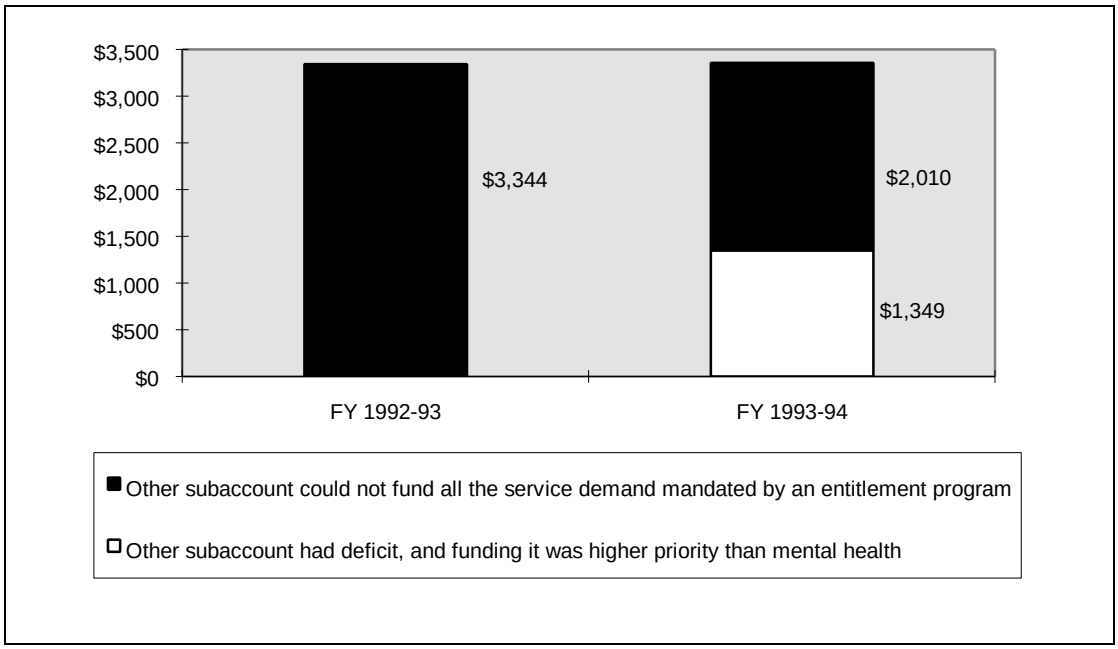
Southern Region
Funds Transferred in: $1,583,000
Funds Transferred out: $0
Net Transfer: $1,583,000

Statewide Total
Funds Transferred in: $5,883,000
Funds Transferred out: $(3,359,999)
Net Transfer: $2,525,000

Source: State Controller and Surveys of Local Mental Health Departments

Figure 9 illustrates the reasons for transfers out of the mental health subaccounts. In FY 1992-93 the transfers, which amounted to $3.3 million, occurred because other subaccounts could not fund all the services mandated by entitlement programs. Nearly $3 million of those transfers were to the Social Services Subaccounts. Transfers in FY 1993-94 occurred for two reasons. Approximately $1.3 million was due to deficits in Health Subaccounts that had higher priority than mental health services. An additional $2 million in transfers resulted from entitlement programs in the Social Services Subaccounts that needed more funding.

Figure 9: Reasons for transfers out of mental health subaccounts (in thousands).

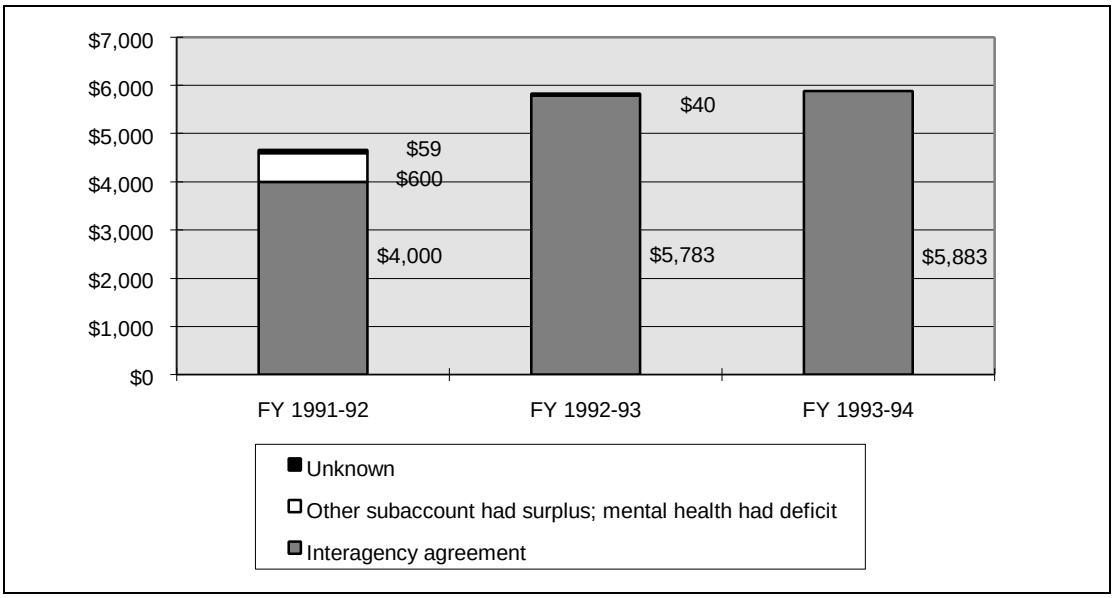


Source: State Controller and Survey of Local Mental Health Directors

When the budget for mental health services was still funded from the State General Fund, it did not fare well in competition with entitlement programs whose budget increases were driven by their case loads. The pattern of subaccount transfers revealed in Figure 9 indicates that the competition with entitlement programs has now shifted to the local level. However, mental health services, which are still not an entitlement, are protected by the dedicated funding provisions and the limit of transferring only up to 10 percent out of the mental health subaccount each year.

Figure 10 shows the reasons for transfers into mental health subaccounts. In all three fiscal years, the predominant reason for transfers was to fund interagency agreements. Most of these transfers were from the Health Subaccounts. Additionally, in FY 1991-92 and FY 1992-93, a small portion of the transfers from the Health Subaccounts and Social Services Subaccounts funded deficits in the Mental Health Subaccounts.

Figure 10: Reasons for transfers into mental health subaccounts (in thousands).



Source: State Controller and Survey of Local Mental Health Departments

Overall, the subaccount transfer provision has benefited the mental health system. The mental health system has experienced a net gain every year since realignment was enacted. In addition, the subaccount transfer provision appears to allow counties to balance competing needs while still preserving the integrity of the trust funds.

Role of Overmatch in Funding the Mental Health System

Finding

Local overmatch has decreased since realignment.

Figure 1 on Page 7 shows the amount of the county overmatch from FY 1985-86 through FY 1993-94. Overmatch increased significantly by $86 million in FY 1990-91, the year after the State reduced funding for community mental health services by $49 million. Overmatch continued to increase until FY 1992-93, and it has decreased since that time.

The decrease of local overmatch may result from the state budget crisis. For two consecutive fiscal years, the State has reduced funding for counties, taking county property taxes in order to pay for education. In FY 1992-93, approximately $2.6 billion was transferred to education. In FY 1993-94, approximately $1 billion was transferred. Without the additional funding provided by overmatch, many local mental health programs will not be able to maintain or expand services to clients until the recession is over and the sales tax revenues start to experience real growth.

Recommendation

The mental health system should evaluate periodically the impact of state budget decisions on local-level funding for mental health services.

Conclusion

Since deinstitutionalization and the advent of the community mental health system, local mental health programs have struggled to obtain funding sufficient to meet the demand for their services. After years of losing ground, local mental health programs chose to support the realignment proposal resulting from the state budget crisis of FY 1990-91.

At the state level, realignment was supposed to stabilize funding for the mental health system. Many factors have caused increases and decreases to mental health funding over the past decade. Just examining funding levels before and after realignment does not clearly reveal whether realignment has stabilized funding. However, the structural change in revenue sources that provided dedicated funding for mental health services and the elimination of competition with entitlement programs in the State General Fund has improved the stability of funding.

Realignment was also supposed to provide for predictable growth in revenue. This goal has not been achieved due to the recession that began in California the year realignment went into effect. The revenue shortfall amounted to $81 million in FY 1991-92. Although a significant increase in Short-Doyle/Medi-Cal reimbursements partially offset that loss, it was still a major blow to local mental health programs. Since that first year, realignment revenue for mental health services grew by approximately 6 percent in FY 1992-93 and did not grow significantly in FY 1993-94. That lack of growth is attributable to a provision that went into effect in FY 1993-94 giving first priority for growth funds to the Caseload Subaccount, which primarily funds growth in the case load of social services programs.

Local revenues have also been affected since realignment. Statewide, the mental health system has benefited from the subaccount transfer provision of realignment with more funds being transferred into mental health subaccounts than transferred out each year. Admittedly, this benefit to the system as a whole is no comfort to those local mental health programs in the Central Valley that have experienced net reductions due to transfers. These transfers are mostly attributable to counties' needing more funds for entitlement programs. Transfers into mental health subaccounts are mostly to fund interagency agreements.

Although not a result of realignment per se, local overmatch has decreased since the implementation of realignment. Overmatch peaked in FY 1990-91 in response to significant reductions in funding at the state level. However, since FY 1992-93 counties have reduced their overmatch due in part to the State's actions in dealing with its own budget crisis. Diversion of counties' property tax revenue to fund education affected their ability to fund other local services.

On the whole, the funding structure of realignment has potential for improving the revenue picture for local mental health programs. The onset of California's recession clouds the picture, however. The mental health system should reevaluate the funding provisions of realignment after California has experienced several years of economic growth.

CHAPTER 3

PERFORMANCE OUTCOME MEASURES AS A TOOL FOR ACCOUNTABILITY

...[the performance outcome measure process] centralizes accountability, gives a target population to serve, and demands outcomes. I would ask you: do you know of any governmental agency developing outcome measures? Realignment's major commitment is to develop a client-centered system. Therefore, we need to develop services which truly meet the needs of our consumers. To do this we must be accountable to our consumers and family members. Realignment has moved us further in developing a more responsive system by demanding that we measure what we do.

James Broderick, Ph.D., Director, Shasta County Mental Health
Public Hearing: Redding, CA, July 25, 1994

Impetus for Developing Performance Outcome Measures

Realignment gave local mental health departments greater flexibility over their resources and greater autonomy to develop mental health systems that respond to their unique local needs. In addition, realignment incorporated many aspects of system reform advocated by the *California Mental Health Master Plan*. These system reform proposals aimed to create a mental health system that is more responsive to the needs and desires of persons with serious mental illnesses and their family members

Performance outcome measures were established in statute as a counterbalance to greater local flexibility and autonomy and to gauge the system's progress toward accomplishing system reform. In addition, performance outcome measures are designed to make the accomplishments of the mental health system more tangible to policymakers in the Legislature and on county governing bodies. Specifically, performance outcome measures are intended to quantify for each county measurable changes in the lives of clients to determine if mental health services are improving basic aspects of clients' quality of life.

Assessment of the Process for Establishing Policies and Procedures for Collecting Performance Outcome Data

Finding

The project for developing performance outcome measures lacks a forum where stakeholders can formulate mutually acceptable policies for implementing the project.

Responsibility for the project to develop performance outcome measures has been diffused among the primary stakeholders:

- DMH--Welfare and Institutions Code (WIC) Sections 5611 and 5612 require the DMH to establish a Performance Outcome Committee to develop measures of performance for evaluating client outcomes and cost effectiveness of mental health services. WIC Section 5613(b) requires the DMH to make available annually to the Legislature data on county performance.
- Local Mental Health Departments--WIC Section 5613(a) requires counties to report annually on performance outcome data to the MHB/C and to the DMH.

- MHB/Cs--WIC Section 5604.2 requires the MHB/Cs to submit an annual report to the governing body on the needs and performance of the county's mental health system and to review and comment on the county's performance outcome data and communicate their findings to the CMHPC.
- CMHPC--WIC Section 5772(c) requires the CMHPC to review and approve the performance outcome measures. In addition, the CMHPC shall annually review the performance of mental health programs based on performance outcome data and report the findings to the Legislature, the DMH, MHB/Cs, and local governing bodies.
- County Governing Bodies--The governing bodies receive annual reports from the MHB/Cs and the CMHPC on the counties' performance outcomes.

The process for developing performance outcome measures and generating the data for each local mental health program has had many stages. Initially, the DMH established the Performance Outcome Committee required by statute to begin work on the project. The committee consisted of representatives of all the key stakeholders. Its approach to developing outcome measures was based on values, i.e., inquiring about what values the mental health constituency has concerning the provision of mental health services to adults and how those values could manifest themselves in outcome measures. The committee began its work by reviewing the outcome measures developed for the AB 3777 pilot project and the values contained in the Adult System of Care chapter in the *California Mental Health Master Plan.*

Once the committee agreed on all the values for the adult system of care, it generated the outcome measures that would indicate for each value whether the mental health services in each county were improving the quality of clients' lives. Measures were developed along many dimensions, such as living situation, financial status, and employment. When this phase was completed, staff began the task of developing the data collection instrument.

In the course of the project, the committee realized it needed additional expertise in several areas. For example, the committee did not possess the necessary expertise in children's mental health services to craft measures for this target population. Consequently, additional persons expert in children's services were added to the committee. They worked as a subcommittee, reporting their progress periodically to the Performance Outcome Committee. As the time came to determine how to collect the performance outcome data, the committee also realized it lacked the necessary expertise on sampling procedures and details of instrument design. Consequently, a Technical Advisory Committee was established to develop the necessary procedures and report back to the Performance Outcome Committee.

During the process to develop the measures and instrument for the adult system of care, the CMHDA realized that many aspects of this project affected local mental health departments very directly. Local staff would have to find the clients identified in the sample, conduct the interviews to obtain the data, perform all the other administrative tasks to complete the process, and return the surveys to the DMH. Thus, the CMHDA established the Services, Outcomes, and Standards (SOS) Committee to monitor the project and advise the CMHDA on policies it should adopt related to the performance outcome project. Because the chair of the SOS Committee was also a member of the Performance Outcome Committee, he could bring to the committee any concerns or issues that the CMHDA had about the project. All the key stakeholders and the DMH staff could work out mutually satisfactory solutions to those concerns together.

While work was being done on the performance outcome project, a parallel process was underway to review all the state-level advisory structures and to develop a structure at the state and local levels that was consistent with realignment. The result of this project was the creation of the California Mental Health Planning Council, which was given the responsibility to review and approve the outcome measures and to use the data to provide system oversight and accountability for programs operated by the DMH and local mental health departments.

Sometime prior to the establishment of the CMHPC in January 1993, the DMH stopped convening the Performance Outcome Committee and eventually disbanded it. However, the Technical Advisory Committee remained and was still active consulting on technical issues. The Children's Committee also continued its work on children's outcome measures.

Ultimately, the DMH presented the outcome measures for the adult system of care to the CMHPC, and the CMHPC's Adult Committee has reviewed and commented extensively on the measures and on the data collection instrument. The Children's Committee of the CMHPC became involved in developing the outcome measures for the children's system of care and has also reviewed and commented on the instrument being developed. The CMHPC's Older Adult Committee, believing that all three systems of care should be treated the same, recommended that outcome measures be developed for older adults. The committee participated in the development of those outcome measures. The DMH is in the process of developing the instrument.

Quite understandably for a project of such scope and magnitude, complications have arisen among the various stakeholders in implementing the data collection and sampling policies for the adult system of care and in developing the instruments for the children's and older adult's projects. Now, instead of having a central committee where all the stakeholders can meet face to face and develop mutually acceptable policies, each stakeholder has a variety of committees individually reviewing and making recommendations about these policy questions.

The DMH has prepared Figure 11 on Page 22 describing the reporting, advisory, and consultative relationships on this project. The committees involved in this project have multiplied to a dramatic degree. The DMH agrees that this project has become confusing and finds keeping track of the input from all of the committees challenging. Someone interested in the policies and recommendations being developed to implement this project would have to attend at least four different committee meetings to understand the background and rationale for recommendations being developed by the various stakeholders.

The existence of these committees established by the stakeholders is not the problem. Each group has a legitimate need to receive updates on the project and formulate recommendations to the DMH. The problem arises when these recommendations conflict as has happened on issues of sampling technique and instrument design. A central committee where all stakeholders can work out differences no longer exists.

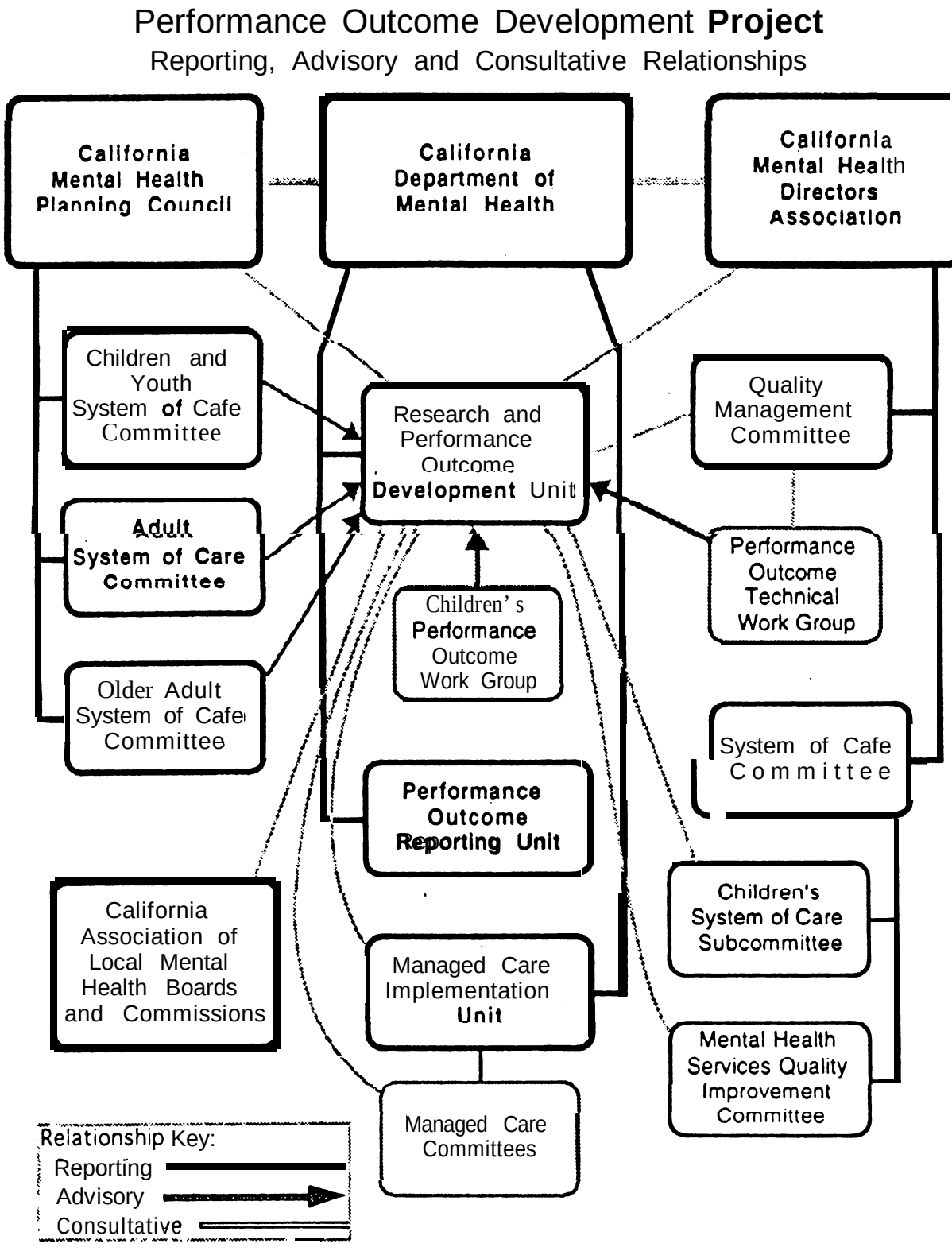
Recommendation

The California Mental Health Planning Council should convene and provide support to a group of key stakeholders involved in implementing this project. This group should provide leadership by developing policy and resolving conflicts among stakeholders on issues related to the performance outcome project. This group should be patterned after the Statewide Training Plan Committee established to implement the joint decision-making process in WIC Section 4061.

Figure 11: Reporting, advisory, and consultative relationships among entities involved with the project to develop performance outcome measures.

Source: State Department of Mental Health

Figure **11: Reporting, advisory, and consultative relationships among entities involved with the project to develop performance outcome measures.**



Source: State Department of Mental Health

Assessment of the Implementation of Performance Outcome Measures

Department of Mental Health

Finding

The DMH needs to provide technical assistance in the analysis and interpretation of performance outcome data to the CMHPC, local mental health departments, and MHB/Cs.

The DMH is responsible for developing and disseminating the survey instruments to local mental health departments and analyzing the data from the completed surveys. Many stakeholders view the DMH as the "bricks and mortar" of the performance outcome measure project. Stakeholders have turned to the DMH for guidance in how to interpret performance outcome data fairly and consistently. The DMH provided an update as of November 1994 on the status of the project for the three target populations:

- Adults--Data are currently being analyzed from the second wave of surveys. These data were collected in each county in the Spring of 1994 from the same cohort of clients used in the first wave. The DMH will compare these data with the first wave of data it collected in the fall of 1993 and will make these comparisons available to each local mental health department. The DMH sent the third wave of surveys to the departments in the fall of 1994. These surveys will be analyzed upon their return after December 1994.
- Children and Youth--The survey instrument for children and youth is currently being pilot tested by eleven local mental health departments that volunteered to participate. The process should be completed by the end of December 1994.
- Older Adults--The draft of the survey for older adults is currently under review. It will be a supplement to the survey for adults.

As a first step in helping the mental health constituency reach a common understanding of performance outcome measures, the Statewide Training Plan Committee sponsored a series of regional workshops. In the fall of 1994, the California Institute for Mental Health issued a report on concerns participants in the training expressed about performance outcome measures. The report issued by the CIMH made several recommendations for the DMH to improve the performance outcome measure project. The CMHPC endorses the following recommendations from that report (CIMH, 1994, pp. 6-7):

Recommendation

- The DMH should develop a preface to accompany every discussion of performance outcome data that reviews the statistical concepts of sampling methodology, validity, and reliability. This preface should include how these methods were applied to the performance outcome data collection techniques, including the process of field testing.
- The DMH should provide a monograph or other document with sufficient information to enable the mental health scientific community to assess the methodology, the data, and their limitations.
- The DMH should make relevant information available to the CMHPC and to all counties to assist in the interpretation of data, including as a minimum:
    1. the Meinhardt prevalence study in a summarized, user-friendly format;
    2. other demographic data available from state sources, such as age distributions, ethnic composition, and poverty levels; and

3. all performance outcome data so each county can do its own data analysis.

Finding

The DMH has not complied with the requirement to develop performance outcome measures for state hospitals.

In addition to requiring the development of performance outcome measures for clients in the community, the statute also requires the DMH to do the same for clients residing in state hospitals. WIC Section 5612(a)(2) requires that measures of performance for evaluating client outcomes and cost-effectiveness of mental health services provided by state hospitals be developed during FY 1992-93. The DMH reports that it has had to prioritize the development of performance outcome measures because it lacks adequate resources to comply with this mandate. Presently, the DMH is working within existing resources to develop and implement performance outcome measures for the three target populations receiving services in the community. After it completes that phase of the project, it hopes to shift staff to develop performance outcome measures for state hospitals.

Lack of performance outcome measures for clients in state hospitals means that this significant component of the mental health system is not being held accountable. Realignment intended to create a client-driven system where all components of the service system were accountable for demonstrating they meet clients' needs.

Recommendation

The DMH should comply with its statutory mandate to develop performance outcome measures for state hospitals as soon as possible.

California Mental Health Planning Council

Finding

The CMHPC has not yet used the performance outcome data for system oversight and accountability.

WIC Section 5772(c) requires the CMHPC to review and approve the performance outcome measures. In addition, it requires that the CMHPC annually review the performance of mental health programs based on performance outcome data and other reports from the DMH and other sources and report the findings to the Legislature, the DMH, MHB/Cs, and local governing bodies.

The CMHPC has been actively involved in developing performance outcome measures and in reviewing survey instruments for the target populations. However, the CMHPC has not yet used the data for system oversight and accountability or begun planning for its use. The CMHPC is waiting for the second wave of data from the adult target population cohort to begin its interpretation of the data. In addition, CMHPC staff have had to devote the majority of their time in 1994 to the preparation of this report, which is required by statute. As a result, the implementation of oversight and accountability of the mental health system envisioned by realignment has been delayed.

This delay has affected other users of performance outcome data. The CMHPC has a direct relationship, which is defined in statute, with the MHB/Cs regarding the interpretation of the performance outcome data for each local mental health program. WIC Section 5604.2(a)(7) requires the MHB/Cs to review and comment on the performance outcome data and report their findings to the

CMHPC. Table 7 on Page 28 reports that 46 percent of the local mental health departments are waiting for instructions from the CMHPC before they work with their MHB/Cs to use the data. In addition, Table 6 on Page 26 shows that 48 percent of the MHB/Cs are awaiting instructions from the CMHPC.

Recommendation

The CMHPC should develop plans as soon as possible for using the performance outcome data, including developing a reporting format for the MHB/Cs to use in reporting their counties' findings to the CMHPC.

County Government

Mental Health Boards/Commissions

Finding

MHB/Cs have not yet begun to work with performance outcome measures.

The statute clearly describes the role of MHB/Cs in using performance outcome data:

- WIC Section 5613(a) requires local mental health departments to provide data on performance outcomes annually to the MHB/Cs;
- WIC Section 5604.2(a)(7) requires the MHB/Cs to review and comment on the data and report their findings to the CMHPC; and
- WIC Section 5604.2(a)(5) requires the MHB/Cs to submit an annual report to the county's governing body on the needs and performance of the local mental health program.

Table 6 indicates that some MHB/Cs have begun to work with the performance outcome data. Thirty-eight percent of the MHB/Cs are relying on regional performance outcome workshops to provide them with training, and 46 percent of the MHB/Cs are receiving training from local mental health department staff.

Although some MHB/Cs have begun to prepare for the performance outcome project, 31 percent have not made any plans for using the data. The reason for the delay by MHB/Cs in implementing the statute may be that some are waiting for the analysis of the second wave of data before they begin to work with performance outcome measures. In addition, 48 percent of the MHB/Cs are waiting for the CMHPC to provide direction on how to use the data to assess their local mental health programs. Those MHB/Cs that indicated they have no plans for using performance outcome data may not be aware of their statutory mandate or their role in the overall performance outcome process. In some cases, the MHB/Cs may be newly appointed or overwhelmed by too many new mandates and issues to address. The MHB/Cs may not feel able to address these issues alone.

Not planning to use performance outcome data puts the MHB/Cs at a distinct disadvantage for being able to review its local mental health program, provide oversight, and advocate effectively for mental health services. One of the reasons performance outcome measures were developed was to respond to objections that the mental health system had no way of proving that funds being spent on services produced any positive outcomes for mental health clients and for society. With the development of outcome measures, advocates will now be able to use these data to demonstrate to policymakers that funds allocated to mental health services are a worthwhile investment. Local mental health programs will be able to use the measures as a self-assessment tool to improve their mental health systems.

Table 6: Have the MHB/Cs planned for working with performance outcome data?

	Bay Area		Central		Sout
	Number of Responses	Percent of Counties Responding	Number of Responses	Percent of Counties Responding	Number of Responses
Waiting for CMHPC to instruct MHB/C on required report	6	50.0%	7	50.0%	6
Training for MHB/C provided by department staff	7	58.3%	5	35.7%	4
Referring data to new or standing committee	6	50.0%	6	42.9%	4
Relying on regional performance outcome workshops	4	33.3%	3	21.4%	6
Planning to hold public hearing on data	2	16.7%	0	0.0%	0
Reporting to governing body on data	1	8.3%	1	7.1%	0
Dissatisfied with statewide project; developing measures locally	1	8.3%	1	7.1%	1
No plans for using performance outcome data	3	25.0%	5	35.7%	3
Grand Total	**30**		**28**		**24**
Number of Counties Responding	**12**		**14**		**9**

Source: Survey of Mental Health Boards/Commissions

Because the DMH has not yet completed the analysis of the second wave of data collected for the adult performance outcome measures, interpretation and use of the data has not begun. In the meantime, however, MHB/Cs that are not making plans to use the data are losing valuable time that they could spend familiarizing themselves with the project, discussing it with local constituents, and laying the groundwork with county supervisors for future advocacy.

Recommendation

- The DMH, in conjunction with the CMHPC, should provide annual training on performance outcome measures to the MHB/Cs and other interested parties.
- The CMHPC should prepare an informational pamphlet appropriate to all stakeholders providing background on the project and guidance in interpreting performance outcome data.
- The CMHPC should provide more direction and leadership to the MHB/Cs on using performance outcome measures.

Local Mental Health Departments

Finding

Local mental health departments should increase their efforts to educate MHB/Cs on how to use performance outcome data.

Performance outcome measures were developed to serve as a tool for program accountability and to measure the effectiveness of services to mental health clients. The statute regarding use of performance outcome data specifies duties for both local mental health departments and MHB/Cs:

- WIC Section 5613(a) requires that the counties report annually to the MHB/Cs on performance outcome data.
- WIC Section 5604.2(a)(7) requires the MHB/Cs to review and comment on the county's performance outcome data.

Table 7 on Page 28 shows efforts by local mental health departments in planning to work with MHB/Cs to use performance outcome data:

- 44 percent relied on regional workshops on performance outcome measures to orient MHB/Cs;
- 39 percent of the local mental health departments are taking a more proactive role by having local staff develop training for MHB/C members; [4] and
- 13 percent are working with MHB/Cs to use the data to improve the system.

[4] Although 39 percent is lower than the 46 percent of the MHB/Cs that report receiving training from their local mental health departments on performance outcome measures, the different percentages are an artifact of the number of mental health departments and MHB/Cs that responded to the surveys. In actual numbers, 21 mental health departments report training their MHB/Cs and 22 MHB/Cs report receiving training so the numbers are quite consistent.

Table 7: Have local mental health departments planned for working with MHB/Cs to use performance outcome data

	Bay Area		Central		Sout
	Number of Responses	Percent of Counties Responding	Number of Responses	Percent of Counties Responding	Number of Responses
Waiting for CMHPC to instruct MHB/C on report	5	45.5%	9	52.9%	3
Relying on regional workshops on performance outcome measures	3	27.3%	6	35.3%	7
Training for MHB/C members provided by department staff	3	27.3%	6	35.3%	6
Working with MHB/C to use data to improve program	2	18.2%	0	0.0%	3
Requesting MHB/C to hold public hearing	1	9.1%	1	5.9%	0
Providing data and its implication to MHB/C	1	9.1%	1	5.9%	0
MHB/C will use the data to determine cultural competency of local delivery system	0	0.0%	1	5.9%	0
Department and MHB/C will use data in annual report to governing body	0	0.0%	0	0.0%	0
No plans	3	27.3%	1	5.9%	0
Grand Total	**18**		**25**		**19**

Number of Counties Responding	**11**		**17**		**10**

Source: Survey of Local Mental Health Departments

To implement performance outcome measures effectively, local mental health departments need to increase their efforts to educate MHB/Cs on how to use the data. Some inaction may be attributed to the mental health constituency's decision to wait for the results from the second wave of data on performance outcome measures for adults before starting to use the data. In addition, 46 percent of local mental health departments are waiting for the CMHPC to give direction on how to use the data.

As already reported, over 30 percent of the MHB/Cs have no plans for using performance outcome data. In addition to the responsibility the CMHPC must take for this situation, local mental health departments also share responsibility for not being more proactive in developing strategies with their MHB/Cs for using the data locally.

Recommendation

All local mental health departments should make an effort to educate and include the MHB/Cs in all aspects of the performance outcome process.

Finding

Although local mental health departments have planned various means to integrate performance outcome data into their quality management systems, few are planning to share the results with the clients who provided the data.

One intention of realignment was to use performance outcome measures as a tool for program accountability and to measure the effectiveness of services to mental health clients. Table 8 on Page 30 illustrates the means by which local mental health departments are integrating performance outcome measures into their quality management systems:

- 77 percent of the local mental health departments plan to refer the data to their MHB/Cs for review and comment;
- 74 percent plan to use the data to develop quality improvement projects;
- 68 percent plan to provide the data to all clinical staff in county-operated programs;
- 61 percent plan to use the data as an evaluation tool; and
- 39 percent plan to share the data with their contract agencies.

Of note, only 18 out of 57 of the local mental health departments, 32 percent, plan to share the measures with the direct consumers who provided the data.

Most local mental health departments may not be planning to share the data with the direct consumers because they do not view this procedure as having any relationship to their quality management systems. However, not sharing these results with the direct consumers who provided the data is inconsistent with the client-driven philosophy. In addition, local mental health departments may lose opportunities to obtain valuable insights into the results from the clients who provided the data. For example, local mental health departments could convene focus groups or task forces of those clients to review and discuss the implications of the data.

Recommendation

- Local mental health departments should involve clients who provided the data on performance outcome measures to ensure their systems are client-driven and to obtain useful insights into their service systems.
- MHB/Cs should review the progress of local mental health departments in integrating performance outcome measures into the quality management systems.

Table 8: Have local mental health departments planned for integrating performance outcome measures into their qua

	Bay Area		Central		Sout
	Number of Responses	Percent of Counties Responding	Number of Responses	Percent of Counties Responding	Number of Responses
Refer to MHB/C for review and comment	11	91.7%	12	66.7%	9
Use to develop quality improvement projects	11	91.7%	12	66.7%	9
Provide to all clinical staff in county-operated programs	10	83.3%	9	50.0%	10
Use as evaluation tool	8	66.7%	7	38.9%	11
Share with direct consumers and family members	7	58.3%	9	50.0%	6
Use for planning and system design	8	66.7%	6	33.3%	10
Provide to governing body	8	66.7%	6	33.3%	5
Provide to contract agencies	7	58.3%	6	33.3%	7
Use to revise treatment plans	4	33.3%	5	27.8%	8
Share with direct consumers who provided the data	5	41.7%	3	16.7%	5
Integrate into Coordinated Care Community Functioning Evaluation	2	16.7%	0	0.0%	0
Use to ensure that local program better meets community needs	1	8.3%	0	0.0%	1
Use to develop local performance outcome measures	1	8.3%	0	0.0%	1
No plans	0	0.0%	3	16.7%	0
Data only minimally helpful to clinicians and consumers	1	8.3%	0	0.0%	0
Not going to use data because of perceived methodological problems	1	8.3%	0	0.0%	0
Grand Total	**85**		**78**		**82**
Number of Counties Responding	**12**		**18**		**11**

Source: Survey of Local Mental Health Departments

Governing bodies

Finding

Most county supervisors surveyed have received information about performance outcome measures and believe the outcome measures will improve local policymaking.

WIC Section 5604.2(a)(5) involves the governing bodies in each county in the performance outcome process by requiring that MHB/Cs report to the governing bodies on their counties' performance.

Table 9 reports that, although 64 percent of the county supervisors who were surveyed have received information about performance outcome measures, over a third are not aware of performance outcome measures apparently because their local mental health departments or MHB/Cs have not informed them. Table 10 shows that 59 percent of the county supervisors who are aware of performance outcome measures believe the measures will improve local policymaking.

Table 9: Have county supervisors received information about performance outcome measures?

	Yes		No			
Region	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Total Number of Counties	Total Percent of Counties
Bay Area	6	66.7%	3	33.3%	9	100.0%
Central	7	58.3%	5	41.7%	12	100.0%
Southern	7	77.8%	2	22.2%	9	100.0%
Superior	7	58.3%	5	41.7%	12	100.0%
Statewide	**27**	**64.3%**	**15**	**35.7%**	**42**	**100.0%**

Source: Survey of County Supervisors

Table 10: Do county supervisors who have received information about performance outcome measures believe they will improve local policymaking?

	Yes		No		No Answer			
Region	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Total Number of Counties	Total Percent of Counties
Bay Area	2	33.3%	1	16.7%	3	50.0%	6	100.0%
Central	5	71.4%	1	14.3%	1	14.3%	7	100.0%
Southern	7	100.0%	0	0.0%	0	0.0%	7	100.0%
Superior	2	28.6%	1	14.3%	4	57.1%	7	100.0%
Statewide	**16**	**59.3%**	**3**	**11.1%**	**8**	**29.6%**	**27**	**100.0%**

Source: Survey of County Supervisors

Communicating with governing bodies about performance outcome measures will increase awareness of the purpose of the measures. If governing bodies realize the mental health system can demonstrate its cost-effectiveness, they will probably more readily support local mental health departments and MHB/Cs in efforts to increase funding for local mental health programs.

Recommendation

Local mental health departments and MHB/Cs that have not emphasized educating governing boards about performance outcome measures should do so.

Conclusion

Performance outcome measures were established in statute as a counterbalance to the greater flexibility and autonomy provided to local mental health departments. Their purpose is to provide a mechanism for holding the mental health system accountable and to gauge the system's progress toward accomplishing system reform. Because of the complexity of the project and lack of precedence, developing performance outcome measures and data collection instruments has been a lengthy process. The mental health constituency also decided not to use the data until two waves of data from the adult instrument were available. As a result, performance outcome measures have not yet begun to function as a source of accountability.

In preparation for using the first two waves of data, which should be available early in 1995, stakeholders can take many steps that will improve the project. Disagreements have arisen between the various stakeholders in the project over aspects of implementation. Because the Performance Outcome Committee established in statute no longer exists, stakeholders do not have a forum to resolve their differences. The CMHPC should convene a joint decision-making group to serve this purpose. In addition, the CMHPC should begin to develop a closer working relationship with MHB/Cs, including developing a reporting format they can use to provide information to the CMHPC that aids in interpreting the data.

The DMH can advance the implementation of the project by providing technical assistance to stakeholders in the analysis and interpretation of the data, including descriptions of the statistical concepts involved. The DMH should also provide a context for interpreting the data, such as the prevalence of mental illness in each county and various demographic and socio-economic data. Moreover, so that all components of the mental health system are subject to the accountability envisioned in realignment, the DMH should develop performance outcome measures for state hospitals as required by statute.

More local mental health departments and MHB/Cs should also take steps to prepare for the use of performance outcome data. Although local mental health departments have generally made plans for integrating performance outcome measures into their quality management systems, they should increase their efforts to educate MHB/Cs on the project. Similarly, MHB/Cs need to take greater responsibility for obtaining the information they need on the purpose of performance outcome measures, what their role is in providing accountability on the local level, and how to interpret the data.

A very encouraging finding is that county supervisors who are aware of the performance outcome measures project believe the measures will improve local policymaking. However, more local mental health departments and MHB/Cs need to educate county supervisors about performance outcome measures because over a third of the supervisors responding to the survey were not aware of the project.

CHAPTER 4

EFFECTS OF REALIGNMENT ON GOVERNANCE STRUCTURES AT THE LOCAL LEVEL

Local Mental Health Departments

Fiscal changes have made an impact in the counties' ability to make long-range plans. Given a more predictable and expansive revenue stream, counties can now plan ahead. For example, Contra Costa county is beginning to follow its five-year master plan. Several other large to moderate sized counties were also able to begin implementing long-range plans.

Town Hall Meeting on Program Realignment
San Francisco, CA, May 27, 1994

Finding

Local mental health departments have done planning for their systems of care.

Realignment gave local mental health departments greater flexibility and autonomy to plan their mental health systems to meet the needs of their communities. Local mental health departments are able to develop services appropriate to serve their own clients. Table 11 shows that 60 percent of local mental health departments have instituted systemwide planning efforts to redesign systems of care. The Bay Area and the Southern regions rank the highest with over 80 percent of the local mental health departments in those regions planning for their systems of care. One half of local mental health departments in the Superior region and 39 percent of the departments in the Central region have instituted systemwide planning efforts.

Table 11: Have local mental health departments instituted systemwide planning efforts to redesign systems of care?

	Yes		No			
Region	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Total Number of Counties	Total Percent of Counties
Bay Area	10	83.3%	2	16.7%	12	100.0%
Central	7	38.9%	11	61.1%	18	100.0%
Southern	9	81.8%	2	18.2%	11	100.0%
Superior	8	50.0%	8	50.0%	16	100.0%
Statewide	**34**	**59.6%**	**23**	**40.4%**	**57**	**100.0%**

Source: Survey of Local Mental Health Departments

Children and Youth

Table 12 on Page 34 shows that statewide 60 percent of local mental health departments have done planning for their children's system of care. Regional variations do exist, however. Over 80 percent of the departments in the Bay Area and Southern regions did planning. But, the percentage drops to 50 percent in the Superior region and goes down to 39 percent in the Central region.

Adults

Table 12 shows that statewide 54 percent of the local mental health departments are doing planning for their adult systems of care. Regionally, 83 percent of local mental health departments in the Bay

Area are doing planning for adults; 73 percent in the Southern region; and approximately 38 percent in both the Central and Superior regions.

Older Adults

Table 12 shows that statewide, 44 percent of local mental health departments are doing planning for their older adult systems of care. Regionally, 75 percent of local mental health departments in the Bay Area are doing planning for older adults; 73 percent in the Southern region; and approximately 25 percent in the Central and Superior regions.

Table 12: Have local mental health departments done planning for each system of care?

		Children and Youth		Adults		Older Adults	
Region	Number of Counties Responding to Survey	Number of Counties Planning	Percent of Counties Planning	Number of Counties Planning	Percent of Counties Planning	Number of Counties Planning	Percent of Counties Planning
Bay Area	12	10	83.3%	10	83.3%	9	75.0%
Central	18	7	38.8%	7	38.8%	4	22.2%
Southern	11	9	81.8%	8	72.7%	8	72.7%
Superior	16	8	50.0%	6	37.5%	4	25.0%
Statewide	**57**	**34**	**59.6%**	**31**	**54.4%**	**25**	**43.9%**

Source: Survey of Local Mental Health Departments

The Central and Superior regions both have lower percentages for planning for all three systems of care. In the Superior region, smaller counties may not have an extensive planning component in their local mental health departments. Some small counties may not have enough target population members to do planning. In the Central region, these counties may be less affluent than the more developed Bay Area and Southern counties. Fewer resources with which to plan would directly effect the extent to which local mental health departments engaged in planning.

Table 13, Table 14, and Table 15 show which stakeholders local mental health departments involved in planning for all three systems of care since the enactment of realignment. In all three systems of care, local mental health departments were inclusive in their planning efforts, involving substantial amounts of stakeholders. For example, 70 to 80 percent of the local mental health departments involved staff from contract agencies in planning. Approximately 90 percent involved MHB/Cs, and 64 to 77 percent involved other mental health constituency groups.

Finding

Local mental health departments are not involving enough public agencies in their planning for adult systems of care.

> *...while Realignment has loosened up many funding restrictions that prevented service integration, there are still some important service areas that have yet to be integrated. There has been a failure to integrate rehabilitation services with mental health programs...[and a] lack of integration between mental health and alcohol and drug abuse programs in many counties.*
>
> *Town Hall Meeting on Program Realignment*
> *San Francisco, CA, May 27, 1994*

"The Planned System of Care for Adults" chapter in the *California Mental Health Master Plan* recommends that local mental health departments develop interagency agreements with other agencies serving the target population to ensure delivery and coordination of all services and opportunities for all clients of local mental health programs.

Table 13: What stakeholders did local mental health departments involve in planning for the children's systems of car

	Bay Area		Central		Sou
	Number of Responses	Percent of Counties Responding	Number of Responses	Percent of Counties Responding	Number of Responses
Mental health dept. administrative staff	10	100.0%	6	100.0%	9
County-operated program staff	10	100.0%	5	83.3%	9
Contract agency staff	9	90.0%	5	83.3%	8
Labor unions	5	50.0%	0	0.0%	1
Direct consumers	8	80.0%	3	50.0%	4
Family members	8	80.0%	4	66.7%	6
MHB/C members	10	100.0%	5	83.3%	8
Other mental health constituency groups	8	80.0%	3	50.0%	6
Other public agencies	4	40.0%	3	50.0%	5
Grand Total	**72**		**34**		**56**
Number of Counties Responding	**10**		**6**		**9**

Source: Survey of Local Mental Health Departments

Table 14: What stakeholders did local mental health departments involve in planning for the adult systems of care?

	Bay Area		Central		Sou
	Number of Responses	Percent of Counties Responding	Number of Responses	Percent of Counties Responding	Number of Responses
Mental health dept. administrative staff	10	100.0%	6	100.0%	8
County-operated program staff	10	100.0%	5	83.3%	8
Contract agency staff	9	90.0%	5	83.3%	8
Labor unions	6	60.0%	1	16.7%	2
Direct consumers	9	90.0%	4	66.7%	7
Family members	9	90.0%	4	66.7%	7
MHB/C members	10	100.0%	5	83.3%	8
Other mental health constituency groups	9	90.0%	3	50.0%	7
Other public agencies	1	10.0%	1	16.7%	2
Grand Total	**73**		**34**		**57**
Number of Counties Responding	**10**		**6**		**8**

Source: Survey of Local Mental Health Departments

Table 15: What stakeholders did local mental health departments involve in planning for the older adult systems of ca

	Bay Area		Central		Sou
	Number of Responses	Percent of Counties Responding	Number of Responses	Percent of Counties Responding	Number of Responses
Mental health dept. administrative staff	9	100.0%	4	100.0%	8
County-operated program staff	9	100.0%	4	100.0%	8
Contract agency staff	9	100.0%	2	50.0%	6
Labor unions	5	55.6%	0	0.0%	0
Direct consumers	8	88.9%	2	50.0%	4
Family members	8	88.9%	3	75.0%	5
MHB/C members	9	100.0%	4	100.0%	7
Other mental health constituency groups	8	88.9%	4	100.0%	5
Other public agencies	2	22.2%	1	25.0%	3
Statewide	**67**		**24**		**46**
Number of Counties Responding	**9**		**4**		**8**

Source: Survey of Local Mental Health Departments

Table 13, Table 14, and Table 15 on the previous pages reveal differences among local mental health departments in the extent to which they involved other public agencies in planning for their various systems of care. In the children's systems of care, 46 percent of the local mental health departments reported involving county agencies. In the older adult systems of care, 36 percent reported involving county agencies. However, in the adult systems of care, only 20 percent reported involving county agencies.

One reason more local mental health departments have involved county agencies in the children's and older adult systems of care is that these target populations have not always had the attention or resources that the adult systems of care have been given. As a result, systems of care for children and older adults have had to rely on other agencies to assemble sufficient resources to serve their target populations. In addition, pilot programs created by legislation have linked the children's systems of care to other service systems, such as education, probation, and child welfare. The multiple needs of older adults also link that system of care to other county agencies, such as Adult Protective Services, public health agencies, and the Conservator's Office. The adult system of care has actually developed in greater isolation than the other systems of care.

Interagency agreements have proved to be an efficient and cost-effective way to maximize scarce resources. Adult systems of care have not taken advantage of all opportunities for interagency agreements, which could maximize limited resources, limit duplicative services, and provide more continuity for mental health clients.

Recommendation

When planning for adult systems of care, local mental health departments should involve all federal, state, and county agencies necessary to develop a comprehensive system of care. Many opportunities present themselves:

- county health departments for the implementation of managed care;
- Department of Rehabilitation district offices to increase opportunities for employment;
- Social Security Administration Offices to improve access to benefits for clients;
- community colleges to increase supported education programs;
- local housing authorities to increase the supply of affordable housing; and
- alcohol and drug programs for services to clients with dual diagnoses.

Governing Bodies

> *...[I]n the past, the lack of clear responsibility allowed the counties to blame the state, who would blame the county, and so on....[C]onsolidating responsibility and authority at the local level clearly identifies the Board of Supervisors as the government body responsible for mental health policy....[S]hifting fiscal responsibility to the local level creates strong incentives for the Board of Supervisors to get involved in mental health policy....[S]hifting authority to the local level may create an opportunity for mental health interests to have greater input into government decision-making.*
>
> *Town Hall Meeting on Program Realignment*
> *San Francisco, CA, May 27, 1994*

Finding

Some governing bodies are becoming more involved in mental health decision making.

Realignment strived to create a closer relationship within the counties so that governing bodies would become more engaged in mental health decision making through communication with MHB/Cs and the mental health constituency. Table 16 shows that 15 percent of local mental health departments believe that their governing bodies have always been very engaged and that realignment has not changed their level of engagement. Other local mental health departments, however, report that governing bodies are increasing their decision-making activities on mental health issues:

- 27 percent report county supervisors ask more questions about budget issues during board meetings;
- 14 percent believe the county supervisor who is the designated member of the MHB/C or his or her aide attends more MHB/C meetings; and
- 12 percent of the county supervisors have directed their aides to be more involved in mental health issues.

Table 17 on Page 40 shows the extent of the involvement with the MHB/C of the county supervisors designated to serve on the MHB/C:

- 55 percent of the county supervisors regularly attend the MHB/C meetings;
- 19 percent regularly attend and receive information and recommendations; and
- 10 percent send an aide to MHB/C meetings and receive information and recommendations.

Mental Health Boards/Commissions

> *While there are mental health advisory boards in each county made up of community members, including clients and families, which are supposed to have input into local mental health policies, it appears, in some cases, that the advisory boards are very reliant on the county mental health director or the Board of Supervisors. Several focus group members described ways in which mental health directors and/or the Board of Supervisors were able to reduce the power of the advisory boards so that their influence was pro forma rather than real and effective. These strategies included: withholding information and resources, appointing uninterested people to key advisory positions, and scheduling meetings at times when it is difficult to get participation by clients, families, or advocates.*
>
> *...[T]he power of the advisory boards varies with the intentions of the county mental health director and the interest of the County Board of Supervisors in mental health services. These problems with county directors and supervisors...are partially the result of a lack of state structure and resources to support the advisory boards, in addition to the geographical isolation and lack of communication between advisory boards.*
>
> *Town Hall Meeting on Program Realignment*
> *San Francisco, CA, May 27, 1994*

Table 16: Are governing bodies more engaged in decision making on mental health issues since realignment?

	Bay Area		Central		Sout
	Number of Responses	Percent of Counties Responding	Number of Responses	Percent of Counties Responding	Number of Responses
Ask more questions about budget issues during board meetings	3	27.3%	4	23.5%	2
Have always been very engaged	3	27.3%	3	17.6%	2
County supervisor or aide attends more MHB/C meetings	0	0.0%	2	11.8%	1
Request special agenda items related to mental health	3	27.3%	2	11.8%	0
Direct their aides to be more involved in mental health issues	2	18.2%	2	11.8%	0
Interest in mental health issues heightened by realignment	2	18.2%	1	5.9%	0
Involvement with MHB/C keeps governing body informed	0	0.0%	1	5.9%	0
More interested in mental health because no co. general funds involved	0	0.0%	0	0.0%	1
Increased interest due to managed care	0	0.0%	1	5.9%	0
Directed CAO to be more involved in mental health issues	0	0.0%	1	5.9%	0
No change	4	36.4%	7	41.2%	4
Less engaged	1	9.1%	1	5.9%	0
Less interested because no county general funds involved	0	0.0%	0	0.0%	1
Grand Total	**18**		**25**		**11**
Number of Counties Responding	**11**		**17**		**10**

Source: Survey of Local Mental Health Departments

Table 17: Extent of county supervisors' involvement with MHB/Cs.

	Bay Area		Central		Sout
	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Number of Counties
Regularly attends meeting	3	33.3%	6	50.0%	4
Regularly attends meeting and sends aide	0	0.0%	0	0.0%	1
Regularly attends meeting and receives information and recommendations	2	22.2%	4	33.3%	2
Sends aide to meeting	2	22.2%	0	0.0%	1
Sends aide to meeting and receives information and recommendations	2	22.2%	1	8.3%	1
Receives information and recommendations	0	0.0%	1	8.3%	0
Grand Total	**9**	**100.0%**	**12**	**100.0%**	**9**

Source: Survey of County Supervisors

Implementation of Statutory Requirements for the Composition and Appointment of Mental Health Boards/Commissions

Establishing a Mental Health Board or Commission

Finding

Nearly all counties surveyed had a MHB/C.

The statute specifies in WIC Section 5604 that each county shall have a local mental health board. Only one county does not have a MHB/C. Being a very small, rural county, its small population and geographical location are obstacles that make sustaining an active MHB/C difficult. As a result, the citizens in that community do not have the opportunity to review mental health services and advise the governing body.

Recommendation

The DMH should contact the mental health director and the governing body for that county and urge compliance with the requirement that it have a MHB/C.

Finding

Most MHB/Cs are called boards.

The statute specifies in WIC Section 5604(g) that each county shall have a local mental health board, which it may call a board or commission. The predominant term for a MHB/C is "board." Table 18 shows that statewide 84 percent have chosen the term "board." The Bay Area and Southern regions use the term "commission" more frequently than do the Central and Superior regions.

Table 18: Term used for mental health board or commission.

	Board		Commission			
Region	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Total Number of Counties	Total Percent of Counties
Bay Area	9	75.0%	3	25.0%	12	100.0%
Central	13	92.9%	1	7.1%	14	100.0%
Southern	7	75.0%	3	30.0%	10	100.0%
Superior	12	92.3%	1	7.7%	13	100.0%
Statewide	**41**	**83.7%**	**8**	**16.3%**	**49**	**100.0%**

Source: Survey of Mental Health Boards/Commissions

Composition Requirements

County Supervisor as Member

Finding

Most MHB/Cs have a member of their governing body on their MHB/C.

The statute specifically requires in WIC Section 5604(a) that one member of the county's governing body be on the MHB/C. The intent of this requirement is clear: to establish a working partnership between governing bodies and MHB/Cs and to increase the knowledge and awareness of county supervisors about the local mental health programs. Table 19 indicates very good compliance, 94 percent, with the requirement that a member of the county's governing body sit on MHB/Cs. However, three counties in three different regions do not have a governing body representative on their MHB/Cs.

Table 19: Number of county supervisors on MHB/Cs.

	No Supervisors		1 Supervisor		2 Supervisors			
Region	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Total Number of Counties	Total Percent of Counties
Bay Area	1	8.3%	4	91.7%	0	0.0%	12	100.0%
Central	1	7.1%	12	85.7%	1	7.1%	14	100.0%
Southern	1	10.0%	8	80.0%	1	10.0%	10	100.0%
Superior	0	0.0%	12	92.3%	1	7.7%	13	100.0%
Statewide	**3**	**6.1%**	**43**	**87.8%**	**3**	**6.1%**	**49**	**100.0%**

Source: Survey of Mental Health Boards/Commissions

Governing bodies in those counties that do not have a member on the MHB/C may be unaware that the statute requires membership, or these governing bodies may not view membership on the MHB/C as a priority. Realignment intentionally shifted more control over funding and program design to the county level so that decisions affecting mental health services were at a level of government closer to the recipients of those services. The rationale for this shift was that local advocates could influence county government more effectively than they could the State Legislature. Having a county supervisor on the MHB/C is designed to strengthen the ties between the MHB/C and the governing body. This provision aims to ensure that at least one county supervisor is very well informed about the mental health system and its needs. These aims are thwarted in the three counties without county supervisors on the MHB/Cs.

Recommendation

In those counties that do not have a county supervisor on the MHB/C, the mental health directors and MHB/Cs in these counties should urge their governing bodies to comply with the requirement that their members serve on the MHB/Cs.

Direct Consumer and Family Member Representation

Questions and concerns of family members and direct consumers related to systems of care for adults and children are being handled better by Merced County's [MHB/C] due to these representatives' direct input and use of personal experiences in their work on the [MHB/C].

Kevin Albrigo, Merced County Mental Health Department
and Alliance for the Mentally Ill of Merced County
Public Hearing: Fresno, CA, August 22, 1994

Finding

Almost one-half of MHB/Cs in large counties do not have sufficient representation of direct consumers and family members.

In keeping with the client-driven philosophy, WIC Section 5604(a)(1) requires that in counties with populations over 80,000 at least 50 percent of the members on MHB/Cs must be direct consumers and family members with at least 20 percent consumers and at least 20 percent family members.

Table 21 on Page 44 reveals that only 53 percent of MHB/Cs in large counties are in full compliance. An additional 18 percent comply with the 50 percent requirement, but consumers are underrepresented. Moreover, Table 20 illustrates that family members are being appointed to MHB/Cs in much higher numbers than direct consumers. The proportion of family members on MHB/Cs ranges from 30 to 69 percent in 23 counties. In contrast, only 7 counties have 30 percent or more direct consumers on their MHB/Cs.

Full compliance varies greatly by region. The Bay Area has the highest rate of compliance at 75 percent; followed by the Superior region at 67 percent; and the Central region at 44 percent. The Southern region is the lowest with only 30 percent of MHB/Cs in compliance. In the Southern region, an additional 30 percent of the MHB/Cs do have 50 percent or more of their members who are direct consumers or family members. However, in those cases family members are over-represented, and direct consumer appointments do not reach the 20 percent minimum requirement.

Essentially, direct consumers have the best representation in the Bay Area, and family members are well represented in the Southern region. Adequacy of representation corresponds geographically to the areas of the State where these groups are strongest: consumers have the strongest networks in the Bay Area, and family member organizations are particularly well developed in Southern California.

Difficulty finding qualified consumers to serve on MHB/Cs undoubtedly contributes to this under-representation. In addition, latent stigma, which still permeates all parts of society, may discourage county supervisors from appointing direct consumers. They may be unconsciously more drawn to appointing family members. Under-representation of consumers on MHB/Cs means that the voice and viewpoint of the direct consumer may not be clearly articulated at MHB/C meetings. This condition runs counter to the consumer-driven philosophy, which is one of the building blocks of system reform in realignment.

Table 20: Range of representation of direct consumers and family members on MHB/Cs in counties with populations exceeding 80,000.

	Direct Consumers		Family Members	
Range of Representation	Number of MHB/Cs	Percentage	Number of MHB/Cs	Percentage
0%	1	2.9%	0	0.0%
1-9%	2	5.9%	0	0.0%
10-19%	8	23.5%	4	11.8%
20-29%	16	47.1%	7	20.6%
30-39%	6	17.6%	16	47.1%
40-49%	0	0.0%	3	8.8%
50-59%	1	2.9%	1	2.9%
60-69%	0	0.0%	3	8.8%
70-79%	0	0.0%	0	0.0%
80-89%	0	0.0%	0	0.0%
90-99%	0	0.0%	0	0.0%
Total	34	100.0%	34	100.0%

Source: Survey of Mental Health Boards/Commissions

Table 21: Compliance with statutory requirements for composition of MHB/Cs: Counties with a population exceeding

	Bay Area		Central		Sc
	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Number of Counties
Full Compliance: Combined Total >= 50%;[5] Both >= 20%	9	75.0%	4	30.0%	3
Combined Total >= 50%; Direct Consumers < 20%[6]	2	16.7%	1	30.0%	3
Combined Total < 50 %; Both >= 20 %	0	0.0%	1	11.1%	0
Combined Total < 50%; Both < 20%	0	0.0%	1	10.0%	1
Combined Total < 50 %; Direct Consumers < 20%	1	8.3%	1	10.0%	1
Combined Total < 50%; Family Members < 20 %	0	0.0%	1	20.0%	2
Statewide	**12**	**100.0%**	**10**	**100.0%**	**9**

Source: Survey of Mental Health Boards/Commissions

[5] The symbols ">=" mean "greater than or equal to."
[6] The symbol "<" means "less than."

Recommendation

- Local mental health departments and MHB/Cs should provide more outreach to consumers, including training and leadership development, to help recruit more direct consumers for appointment to MHB/Cs.
- MHB/Cs and mental health directors should work with governing bodies to ensure they understand the statutory composition requirements and make appointments accordingly.

Finding

Most MHB/Cs in small counties comply with composition requirements for direct consumers and family members. However, some small counties exceeding the 5-member minimum requirement do not comply with the composition requirement.

The population limitations of small counties called for some special provisions. WIC Section 5604(a)(2) allowed these small counties to have 5-member MHB/Cs. However, the law still requires that MHB/Cs in counties with populations under 80,000 have at least one consumer and one family member on their MHB/Cs. Table 22 shows that 80 percent of MHB/Cs in small counties are in compliance with this requirement. Table 23 on Page 46 arrays the proportions of family members and direct consumers on the MHB/Cs.

Table 22: Compliance with statutory requirements for composition of MHB/Cs: Counties with populations under 80,000.

	Central		Superior			
	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Total Number of Counties	Total Percent of Counties
Full Compliance: At least 1 Direct Consumer and 1 Family Member	5	100.0%	7	70.0%	12	**80.0%**
At Least 1 Direct Consumer and No Family Members	0	0.0%	1	10.0%	1	**6.7%**
At Least 1 Family Member and No Direct Consumers	0	0.0%	1	10.0%	1	**6.7%**
No Direct Consumers or Family Members	0	0.0%	1	10.0%	1	**6.7%**
Grand Total	**5**	**100.0%**	**10**	**100.0%**	**15**	**100.0%**

Source: Survey of Mental Health Board/Commissions

Table 23: Range of representation of direct consumers and family members on MHB/Cs in counties with populations under 80,000.

	Direct Consumers		Family Members	
Range of Representation	Number of MHB/Cs	Percentage	Number of MHB/Cs	Percentage
0%	2	13.3%	2	13.3%
1-9%	0	0.0%	0	0.0%
10-16%	4	26.7%	1	6.7%
17-32%	5	33.3%	7	46.7%
33-39%	2	13.3%	2	13.3%
40-49%	1	6.7%	2	13.3%
50-59%	0	0.0%	1	6.7%
60-69%	1	6.7%	0	0.0%
70-79%	0	0.0%	0	0.0%
80-89%	0	0.0%	0	0.0%
90-99%	0	0.0%	0	0.0%
Total	15	100.0%	15	100.0%

Source: Survey of Mental Health Boards/Commissions

Six small counties chose to exceed the minimum 5-member size and have expanded to have more members on their MHB/Cs. Table 31 on Page 52 shows that these MHB/Cs have from 10 to 15 members. These six counties generally comply with the requirement that they have at least one direct consumer and one family member. However, their MHB/Cs have as many members as MHB/Cs in large counties. Table 24 evaluates the composition of these six MHB/Cs as if they were held to the composition requirements for boards of comparable size in large counties.

Table 24: Composition of MHB/Cs in counties with populations under 80,000 that choose to exceed the minimum size in statute.

	Central		Superior			
	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Total Number of Counties	Total Percent of Counties
Full Compliance: Combined Total >= 50%; Both >= 20 %[7]	1	33.3%	0	0.0%	1	**16.7%**
Combined Total >= 50%; Direct Consumers < 20%[8]	1	33.3%	0	0.0%	1	**16.7%**
Combined Total < 50%; Both < 20 %	1	33.3%	1	33.3%	2	**33.3%**
Combined Total < 50%; Direct Consumers< 20%	0	0.0%	2	66.7%	2	**33.3%**
Grand Total	**3**	**100.0%**	**3**	**100.0%**	**6**	**100.0%**

Source: Survey of Mental Health Boards/Commissions

The law is not clear about what composition requirement applies to MHB/Cs in small counties that choose to exceed the minimum size. Insufficient representation of consumers and family members on these expanded MHB/Cs results in thwarting one of the basic elements of realignment: the people most affected by mental health services should have a significant voice in planning and receiving those services.

[7] The symbol ">=" means "greater than or equal to."
[8] The symbol "<" means "less than."

Recommendation

The statute should be amended to require that MHB/Cs in counties under 80,000 in population that choose to exceed the minimum size must comply with the composition requirements for large counties.

Ethnic Diversity of Appointments

> *[A] large group of disenfranchised minorities...are not using or participating in the governance of the public mental health system....[W]hat is needed in the public mental health system is greater representation by poor minorities. Difficulties in obtaining such representation were pointed out: individuals who could represent poor minorities probably do not have the resources to participate, or if they do, they are overburdened by participation in too many groups.*
>
> *Town Hall Meeting on Program Realignment*
> *San Francisco, CA, May 27, 1994*

Finding

Most MHB/Cs do not reflect the ethnic diversity of their counties, especially for Latinos and Asians.

WIC Section 5604(a) requires that MHB/C appointments reflect the ethnic diversity of the community. Having balanced representation of a county's ethnic groups on the MHB/C means it can advise the local mental health department and the governing body about the needs and issues of the entire community. Lack of such representation means that an MHB/C may not be addressing issues related to providing culturally competent services.

Local mental health departments and MHB/Cs are not directing sufficient recruitment or outreach efforts to obtain MHB/C applicants from specific ethnic populations.[9] Over-representation by whites and African Americans takes away representation Latinos and Asians should have. Table 25 on Page 49 illustrates that 87 percent of MHB/Cs are at or above parity for whites. Table 26 on Page 49 shows that 89 percent are at or above parity for African Americans. Conversely, Table 27 on Page 50 reveals that 72 percent are below parity for Latinos by as many as 5 members, and Table 28 on Page 50 shows that 49 percent are below parity for Asians by as many as 3 members.

[9] The data used for analyzing this issue was obtained from the Department of Finance Report 93 P-1: "Populations by Race/Ethnicity for California and Its Counties 1990-2040." The Department of Finance reported ethnicity by county for Whites, African Americans, Latinos, and Other. Subsequent data obtained from the Department of Finance, although not entirely compatible with the number of "Other" reported initially, revealed that 88.6 percent of this category were Asians. Asians include Chinese, Filipino, Japanese, Asian Indian, Korean, Vietnamese, Cambodian, Hmong, Laotian, Thai, and Other Asians. Another 3.6 percent were Pacific Islanders. The remaining 7.8 percent were Native Americans. Unfortunately, because the figures in these reports were not sufficiently compatible, the number of Native Americans by county could not be used in this analysis. Because over 92 percent of the population in this category are Asians or Pacific Islanders, it will be referred to as "Asian."

The ideal representation of each ethnic group on a MHB/C was determined by applying the percentage of each ethnic group in each county to the size of its MHB/C. These figures were then compared to the actual representation of the ethnic groups on each MHB/C.

Latino representation is weak in all regions. The Bay Area shows only 8 percent of the MHB/Cs at parity; the Southern region only 13 percent; the Central region 29 percent at or above parity; and the Superior region 54 percent at parity. Asian representation is extremely weak in the Bay Area with only 8 percent of the MHB/Cs at parity.

Recommendation

- Local mental health departments and MHB/Cs should conduct more focused recruitment, outreach, and leadership training to those ethnic groups under-represented on their MHB/Cs.
- Mental health directors and MHB/Cs should communicate with their governing bodies to emphasize the importance of making appointments that reflect the ethnic diversity of the community.

Appointment Process

Finding

Only one-third of the counties use the correct appointment process.

The statute intended the appointment process to foster good communication and a close working relationship between the county supervisor and his or her appointees. Section WIC 5604(a) requires that each county supervisor make an equal number of appointments to the MHB/C. Table 29 on Page 51 indicates that only 37 percent of the counties are in compliance with the appointment process. The Bay Area has the highest rate of compliance at 42 percent. In 35 percent of the counties statewide governing bodies appoint their MHB/Cs at large. Governing bodies in the Superior region used the at-large method 62 percent of the time. Governing bodies in 20 percent of the counties make an unequal number of appointments per county supervisor. Eight percent of the governing bodies combine appointments by individual county supervisors and at-large appointments.

Governing bodies that use a combination of at-large and individual appointments may still have members on their MHB/Cs who were appointed before this statute was enacted. If so, improvement in the rate of compliance should occur with subsequent appointments. Those governing bodies that only make appointments on an at-large basis may not be aware of the requirement or may think an equal number of appointments per county supervisor is not important.

The Superior region may have problems complying with this requirement due to the unequal distribution of population in rural counties. Frequently, appointees to MHB/Cs reside in one or two population centers in these areas, which may be in only one or two county supervisors' districts. Consequently, an at-large appointment process enables the entire board to be involved in appointing the MHB/C. However, failure to comply with the appointment process could result in county supervisors not being familiar with their MHB/Cs and their activities.

Recommendation

Local mental health departments and MHB/Cs should remind their governing boards that the statute requires an equal number of appointments by each county supervisor.

Table 25: Ethnicity of MHB/Cs--Difference between ideal and actual number of Whites.

	Bay Area		Central		Southern	
	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Number of Counties	Perce Cou
Under-represented by 3	2	16.7%	0	0.0%	0	0.0
by 1	1	8.3%	1	7.1%	1	12.
Parity	2	16.7%	4	28.6%	0	0.0
Over-represented by 1	0	0.0%	5	35.7%	3	37.
by 2	5	41.7%	2	14.3%	1	12.
by 3	1	8.3%	0	0.0%	2	25.
by 4	0	0.0%	2	14.3%	1	12.
by 5	1	8.3%	0	0.0%	0	0.0
Grand Total	**12**	**100.0%**	**14**	**100.0%**	**8**	**100**

Source: Survey of Mental Health Boards/Commissions

Table 26: Ethnicity of MHB/Cs--Difference between ideal and actual number of African Americans.

	Bay Area		Central		Southern	
	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Number of Counties	Perce Cou
Under-represented by 1	1	8.3%	2	14.3%	2	25.
Parity	6	50.0%	11	78.6%	4	50.
Over-represented by 1	3	25.0%	1	7.1%	1	12.
by 2	2	16.7%	0	0.0%	1	12.
Grand Total	**12**	**100.0%**	**14**	**100.0%**	**8**	**100**

Source: Survey of Mental Health Boards/Commissions

Table 27: Ethnicity of MHB/Cs--Difference between ideal and actual number of Latinos.

	Bay Area		Central		Southern	
	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Number of Counties	Perce Cour
Under-represented by 5	0	0.0%	0	0.0%	1	12.
by 4	1	8.3%	0	0.0%	0	0.0
by 3	0	0.0%	1	7.1%	1	12.
by 2	5	41.7%	5	35.7%	2	25.
by 1	5	41.7%	4	28.6%	3	37.
Parity	1	8.3%	2	14.3%	1	12.
Over-represented by 1	0	0.0%	2	14.3%	0	0.0
Grand Total	**12**	**100.0%**	**14**	**100.0%**	**8**	**100**

Source: Survey of Mental Health Boards/Commissions

Table 28: Ethnicity of MHB/Cs--Difference between ideal and actual number of Asians.

	Bay Area		Central		Southern	
	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Number of Counties	Perce Cour
Under-represented by 3	1	8.3%	0	0.0%	0	0.0
by 2	4	33.3%	0	0.0%	1	12.
by 1	6	50.0%	5	35.7%	2	25.
Parity	1	8.3%	9	64.3%	5	62.
Over-represented by 1	0	0.0%	0	0.0%	0	0.0
Grand Total	**12**	**100.0%**	**14**	**100.0%**	**8**	**100**

Source: Survey of Mental Health Boards/Commissions

Table 29: Compliance with appointment process required by statute.

	Bay Area		Central		Southe	
Type of Appointment Process	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Number of Counties	P
Full Compliance: Equal Number of appointments per co. supervisor	5	41.7%	5	35.7%	4	
Unequal Number of appointments per co. supervisor	1	8.3%	4	28.6%	4	
Appointments at-large by entire governing body	5	41.7%	2	14.3%	2	
Combination of individual and at-large appointments	1	8.3%	3	21.4%	0	
Grand Total	**12**	**100.0%**	**14**	**100.0%**	**10**	

Source: Survey of Mental Health Boards/Commissions

Finding

The statute is not clear concerning the size of MHB/Cs.

WIC Section 5604(a) specifies that each MHB/C in a large county shall have at least 10 or 15 members. Each member of the governing body is supposed to make an equal number of appointments. One member of the MHB/C is supposed to be a member of the local governing body. In counties with a population less than 80,000, MHB/Cs may have a minimum of five members. Table 30 shows that 68 percent of the MHB/Cs in large counties have 10, 11, 15, or 16 members. Of those, 21 percent have 10 or 15 members, and 47 percent have 11 or 16 members. The remaining 32 percent of the counties have sizes that cannot be interpreted to comply with the statute. Table 31 shows that 26 percent of the MHB/Cs in small counties have 6, 10, or 15 members with 13 percent having 10 or 15 members and 13 percent having 6 members. The remaining 74 percent of the counties have sizes that cannot be interpreted to comply with the statute.

Table 30: Size of MHB/Cs in counties with populations exceeding 80,000.

Size of MHB/C	Number of MHB/Cs	Percentage
0-9	2	**5.9%**
10	1	**2.9%**
11	5	**14.7%**
12-14	8	**23.5%**
15	6	**17.6%**
16	11	**32.4%**
17	1	**2.9%**
Total	**34**	**100.0%**

Source: Survey of Mental Health Boards/Commissions

Table 31: Size of MHB/Cs in counties with populations under 80,000.

Size of MHB/C	Number of MHB/Cs	Percentage
3	1	**6.7%**
6	2	**13.3%**
7-9	6	**40.0%**
10	1	**6.7%**
12-14	4	**26.7%**
15	1	**6.7%**
Total	**15**	**100.0%**

Source: Survey of Mental Health Boards/Commissions

The statute specifies that county supervisors shall make an equal number of appointments. The statute also requires that a county supervisor shall be a member of the MHB/C. Confusion has resulted because the statute does not specify whether the supervisor's membership on the MHB/C is in addition to the appointments he or she makes or whether the county supervisor sitting on the MHB/C counts as one of his or her own appointments. Forty-seven percent of the MHB/Cs in large counties and 13 percent of the MHB/Cs in small counties interpreted the statute to mean that the supervisor's membership on the MHB/C was in addition to the appointments. Twenty-one percent of the MHB/Cs in large counties and 13 percent of the MHB/Cs in small counties interpreted the statute to mean that a supervisor's appointment would count as one of his or her appointments to the MHB/C.

The governing bodies of those counties that do not comply with the statute may not be aware of the size stipulation and appointment process or may not believe that an equal number of appointments

per county supervisor makes any difference. Clarifying the statute to specify that county supervisors' membership on MHB/Cs is in addition to the equal number of appointments they are required to make will maximize opportunities for the mental health constituency to participate on MHB/Cs.

For most MHB/Cs whose size does not comply with either interpretation of the statute, county supervisors are not making an equal number of appointments. As a result, county supervisors who are making fewer appointments may not experience the closer communication with MHB/C members that the change in the appointment process was supposed to foster.

Recommendation

- The statute should be clarified to require that the representative from the governing body be in addition to the equal number of appointments made by each county supervisor to the MHB/C.
- Local mental health departments and MHB/Cs in those counties that are not complying with the appointment process and size requirements should encourage their governing bodies to appoint equal numbers of representatives.

Effectiveness of Mental Health Boards/Commissions in Performing Their Statutory Duties

My experiences with the other regional and state [MHB/C] chairs have left me with great concern regarding the well-being of local boards. Many have described themselves as dysfunctional....The major complaint has been that they are not given vital information for their decision-making processes.

Judie Bradley, Shasta County Mental Health Board
Public Hearing: Redding, CA, July 25, 1994

Finding

MHB/Cs are generally performing all the duties assigned to them in statute.

WIC Section 5604.2 specifies the following responsibilities for MHB/Cs:

- review and evaluate the community's mental health needs, services, facilities, and special problems;
- assess the impact of realignment on services delivered to clients and on the local community;
- review performance contracts the county enters into with the State;
- advise the governing body and the local mental health director on any aspect of the local mental health program;
- review and approve the procedures used to ensure citizen and professional involvement in all stages of the planning process;
- submit an annual report to the governing body on the needs and performance of the county's mental health system;
- review and make recommendations on applicants for the position of local mental health director; and
- perform additional duties the county governing body may transfer to them.

Reports from MHB/Cs on their activities indicate they appear to be performing all the duties assigned to them in statute. This section highlights some of the survey results. Appendix 3 provides a more detailed picture of the results for each statutory duty summarized by region.

Table 87 and Table 88 on Page 126 illustrate the means used by the MHB/Cs in 1993 and 1994 to review mental health needs. MHB/Cs performed a variety of tasks to fulfill this duty. The most frequently performed tasks included having presentations at MHB/C meetings, reviewing facilities and services, and establishing committees. Table 94 and Table 95 on Pages 129 and 130 describe a variety of ways MHB/Cs are advising their mental health directors and governing bodies for 1993 and 1994, including written communication and meetings with both the mental health director and the governing body. In both 1993 and 1994, 94 percent of the MHB/Cs had direct communication between the director and MHB/C chair. Ninety percent in 1993 and 92 percent in 1994 advised the director at monthly MHB/C meetings. Eighty-three percent in 1993 and 90 percent in 1994 indicated that communication occurred between the mental health director and individual MHB/C members. In addition, over 70 percent of the MHB/Cs testified at governing body meetings during the year, and members of over 75 percent of the MHB/Cs communicated with county supervisors individually during the year.

Table 99 on Page 132 shows that 63 percent of the MHB/Cs in 1993 submitted an annual report to their governing bodies. However, 20 percent of the MHB/Cs did not submit an annual report that year because they placed higher priority on other issues. The percentage of the MHB/Cs that reported dealing with issues of a higher priority dropped from 20 percent in 1993 to 4 percent in 1994. These MHB/Cs may have experienced considerable turnover of members and were not able to absorb all the changes in responsibilities brought about by the new statute during their first year of operation. Table 101 on Page 132 shows that for 1994 90 percent of the MHB/Cs have or plan to submit an annual report.

The results of this finding must be qualified. They represent reports by MHB/Cs of their own actions. The fact that MHB/Cs perform these tasks does not provide any information about how effectively they fulfill these duties. In fact, the following section on the effectiveness of MHB/Cs suggests they could improve their performance.

Finding

Although MHB/Cs report performing their duties, their effectiveness is in question.

The realignment legislation charged the DMH with assembling a task force to redesign advisory groups at the state and local level consistent with the changes made by realignment. Out of this project came the provisions of Chapter 1374, Statutes of 1992 (AB 14--Bronzan) that eliminated the Conference of Local Mental Health Directors, the California Council on Mental Health, and the Organization of Local Mental Health Advisory Boards, which had been providing support and technical assistance to mental health advisory boards. AB 14 also created the California Mental Health Planning Council and revised aspects of the statute governing MHB/Cs. The central goal of this legislation was to establish entities at both the state and local levels to provide oversight and accountability to the mental health system as a counterbalance to the increased autonomy and flexibility that realignment provided to local mental health programs.

To that end, specific changes were made to provisions governing MHB/Cs. The appointment process was changed to strengthen the relationship and enhance the communication between county supervisors and their appointees to MHB/Cs. The composition of the MHB/Cs was changed so that at least half of the members were direct consumers and family members. This change was designed to implement the client-driven philosophy so that those most affected by the mental health system, direct consumers and their families, should have a significant role in providing oversight and

accountability. The duties of MHB/Cs were modified to be consistent with realignment, and most importantly, they were augmented to give MHB/Cs a role in using performance outcome data.

Input by MHB/Cs to Local Mental Health Departments and Governing Bodies

The key question is whether these statutory changes achieved their desired purposes. The results of this study indicate that generally they have not. Table 34 on Page 56 reports that 56 percent of local mental health departments have not perceived any change in input from their MHB/Cs. In Table 35 on Page 56, 75 percent of MHB/Cs report that the amount of input they are providing to local mental health departments has not changed. The closer communication between MHB/C members and county supervisors does not seem to have materialized either. Table 36 on Page 57 reports that 84 percent of MHB/Cs have not increased the amount of input they are providing to governing bodies. This result is more pronounced in the Central and Superior regions where 93 percent indicate the amount of input has not changed.

Table 32 presents the county supervisors views about whether changing the appointment process has increased their communications with appointees. Their perceptions are somewhat more positive with 50 percent indicating that communication has increased. However, the pattern of results from the county supervisors is similar to that of MHB/Cs in that supervisors in the Central and Superior regions also report the lowest figures for increased communication.

Table 32: Did changing the appointment process increase communication between county supervisors and their appointees?

	Increased Communication		No Increased Communication			
Region	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Total Number of Counties	Total Percent of Counties
Bay Area	6	66.7%	3	33.3%	9	100.0%
Central	5	41.7%	7	58.3%	12	100.0%
Southern	5	55.6%	4	44.4%	9	100.0%
Superior	5	41.7%	7	58.3%	12	100.0%
Grand Total	**21**	**50.0%**	**21**	**50.0%**	**42**	**100.0%**

Source: Survey of County Supervisors

The consequences of not achieving greater communication with county supervisors are reinforced by data presented in Table 33. Over 95 percent of county supervisors who felt communication had been increased also reported that they believed such communication improved local policymaking. This result underscores the importance of understanding the factors contributing to both the effectiveness and ineffectiveness of MHB/Cs and finding solutions to maximize their performance.

Table 33: Effect of increased communication by MHB/Cs on local policymaking.

	Improved Policymaking		Made Policymaking More Difficult			
Region	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Total Number of Counties	Total Percent of Counties
Bay Area	6	100.0%	0	0.0%	6	100.0%
Central	4	80.0%	1	20.0%	5	100.0%
Southern	5	100.0%	0	0.0%	5	100.0%
Superior	5	100.0%	0	0.0%	5	100.0%
Grand Total	**20**	**95.2%**	**1**	**4.8%**	**21**	**100.0%**

Source: Survey of County Supervisors

Table 34: Do local mental health departments believe that MHB/Cs are providing them with more input than MHB/Cs di

	Bay Area		Central		S
	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Number Counties
No change	5	41.7%	11	61.1%	8
Have always provided input	2	16.7%	2	11.1%	2
Providing more input	0	0.0%	0	0.0%	0
Providing more input on specific aspects of the service system and treatment priorities	3	25.0%	3	16.7%	1
MHB/C members sit on department committees	2	16.7%	1	5.6%	0
Perspective of the direct consumer is more pronounced	0	0.0%	0	0.0%	0
Providing less input	0	0.0%	1	5.6%	0
...because they are overwhelmed	0	0.0%	0	0.0%	0
...because the board is new	0	0.0%	0	0.0%	0
Grand Total	**12**	**100.0%**	**18**	**100.0%**	**11**

Source: Survey of Local Mental Health Departments

Table 35: Do MHB/Cs believe that they are providing more input to local mental health departments than they did prior

	Bay Area		Central		S
	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Number Counties
No change in input provided	9	75.0%	10	76.9%	5
Input increased	0	0.0%	1	7.7%	0
Increased participation in departmental policy development and planning	3	25.0%	1	7.7%	4
Advocated to preserve, establish, or expand services	0	0.0%	0	0.0%	1
Advocated for consumer empowerment	0	0.0%	1	7.7%	0
Grand Total	**12**	**100.0%**	**13**	**100.0%**	**10**

Source: Survey of Mental Health Boards/Commissions

Table 36: Are MHB/Cs providing more input to governing bodies than they did before realignment and statute

	Bay Area		Central		Sout
	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Number of Counties
No change in input provided	9	75.0%	13	92.9%	7
Advised on implementation of managed care	1	8.3%	0	0.0%	1
Advised on housing needs	1	8.3%	0	0.0%	0
Advocated to prevent subaccount transfer	0	0.0%	0	0.0%	1
Advocated successfully to keep clinic open	0	0.0%	0	0.0%	0
Advised on impact of hiring freeze	1	8.3%	0	0.0%	0
Advocated successfully to prevent closure of board and care facility	0	0.0%	0	0.0%	1
Providing less input due to program reductions	0	0.0%	1	7.1%	0
Grand Total	**12**	**100.0%**	**14**	**100.0%**	**10**

Source: Survey of Mental Health Boards/Commissions

Factors Contributing to Effectiveness and Ineffectiveness and Recommendations To Improve Performance

> *Authority concentrated at the local level...may provide local advisory boards and local advocacy groups with a greater opportunity to make an impact on mental health since all decisions are being made within the community....In order for advisory boards, clients, families and advocates to have an impact, they must receive training and resources; clients must be included in the decision-making process; and advocacy groups must organize themselves effectively....Since Realignment, local advisory boards have become heavily dependent on the local director and have had little assistance from the state...In some counties, the local mental health advisory boards and commissions have been reduced to...the mental health director running the board meetings...Over the long-term, there must be greater empowerment of local advisory boards and commissions.*
>
> *Town Hall Meeting on Program Realignment*
> *San Francisco, CA, May 27, 1994*

> *The focus group recommended giving advisory boards funding and technical support; allowing clients, families and advocates to have a say in who is appointed to the board; and developing strategies for improving participation of clients, families and advocates at all levels of decision-making.*
>
> *Town Hall Meeting on Program Realignment*
> *San Francisco, CA, May 27, 1994*

Table 37 lists the following top three factors that MHB/Cs believe contribute to their effectiveness:

- good working relationship with director and local mental health department (90 percent);
- increased direct consumer and family member representation on MHB/C (78 percent); and
- more community involvement (53 percent).

Table 38 on Page 60 lists the following top three factors local mental health departments believe contribute to the effectiveness of MHB/Cs:

- members are hard working, knowledgeable, and interested in the mental health system (43 percent);
- board members are very committed (34 percent); and
- adding more direct consumers and family members to the MHB/C increased its effectiveness (34 percent).

Table 39 on Page 61 shows the top three factors MHB/Cs believe contribute to their ineffectiveness:

- inexperience of newly appointed members (69 percent);
- no mandated or adequately funded statewide organization for MHB/Cs (44 percent); and
- being overwhelmed by too many statutory duties and projects (33 percent).

Table 40 on Page 62 shows the top three factors local mental health departments believe contribute to the ineffectiveness of the MHB/Cs:

- lack of knowledge about mental health issues and need for training (33 percent);
- vacancies and difficulties recruiting board members, especially direct consumers (21 percent); and
- personality conflicts and members with personal agendas (21 percent).

Table 37: Factors MHB/Cs believe contribute to their effectiveness.

	Bay Area		Central		Sout
	Number of Responses	Percent of Counties Responding	Number of Responses	Percent of Counties Responding	Number of Responses
Good working relationship with director and department	11	91.7%	12	85.7%	9
Increased direct consumer and family member representation on MHB/C	9	75.0%	11	78.6%	8
More community involvement	6	50.0%	7	50.0%	5
Active, experienced MHB/C members	2	16.7%	5	35.7%	2
Good relationship with governing body	4	33.3%	1	7.1%	1
Good relationship with contractors and other county departments	1	8.3%	2	14.3%	0
Effective leadership of MHB/C	1	8.3%	0	0.0%	1
Full-time staff for MHB/C	1	8.3%	0	0.0%	1
MHB/C becomes involved at onset of an issue	0	0.0%	0	0.0%	1
Grand Total	**35**		**38**		**28**

Number of Counties Responding	**12**		**14**		**10**

Source: Survey of Mental Health Boards/Commissions

Table 38: Factors local mental health departments believe contribute to the effectiveness of MHB/Cs.

	Bay Area		Central		Sout
	Number of Responses	Percent of Counties Responding	Number of Responses	Percent of Counties Responding	Number of Responses
Members are hard working, knowledge-able, and interested in mental health	4	44.4%	4	33.3%	4
Board members are very committed	3	33.3%	3	25.0%	4
Adding more direct consumers and family members to MHB/C	4	44.4%	5	41.7%	1
Good communication and partnership between MHB/C and department	6	66.7%	0	0.0%	4
Strong, active chairperson and effective leadership	3	33.3%	1	8.3%	2
Board members are effective advocates with governing body	3	33.3%	1	8.3%	0
Changing composition and appointment process has been helpful	1	11.1%	2	16.7%	0
Grand Total	**24**		**16**		**15**
Number of Counties Responding	**9**		**12**		**7**

Source: Survey of Local Mental Health Departments

Table 39: Factors MHB/Cs believe contribute to their ineffectiveness.

	Bay Area		Central		Sout
	Number of Responses	Percent of Counties Responding	Number of Responses	Percent of Counties Responding	Number of Responses
Inexperience of newly appointed members	6	60.0%	8	66.7%	8
No mandated or adequately funded statewide organization for MHB/Cs	4	40.0%	3	25.0%	8
Overwhelmed by too many statutory duties and projects	2	20.0%	3	25.0%	6
Need training about mental health system and board responsibilities	2	20.0%	4	33.3%	1
MHB/C members do not devote sufficient time	3	30.0%	1	8.3%	2
Vacancies and turnover rate	2	20.0%	0	0.0%	2
County policies limit effectiveness of MHB/C	0	0.0%	1	8.3%	3
Director does not consult with MHB/C	1	10.0%	1	8.3%	1
Lack of interest from governing body	2	20.0%	0	0.0%	0
MHB/C perceives itself as ineffective	0	0.0%	2	16.7%	0
Lack of support and funding for MHB/C operation	1	10.0%	1	8.3%	0
Grand Total	**23**		**24**		**31**
Number of Counties Responding	**10**		**12**		**10**

Source: Survey of Mental Health Boards/Commissions

Table 40: Factors local mental health departments believe contribute to the ineffectiveness of MHB/Cs.

	Bay Area		Central		Sout
	Number of Responses	Percent of Counties Responding	Number of Responses	Percent of Counties Responding	Number of Responses
Lack of knowledge about mental health issues and need for training	0	0.0%	3	42.9%	2
Vacancies and difficulties recruiting board members, especially direct consumers	2	66.7%	0	0.0%	1
Personality conflicts and members with personal agendas	0	0.0%	2	28.6%	2
Turnover rate and member burnout	1	33.3%	1	14.3%	0
Delay implementing AB 14	0	0.0%	1	14.3%	2
Members unclear about roles and responsibilities of boards	1	33.3%	0	0.0%	0
Large geographic areas with small populations make assembling a board and holding meetings difficult	0	0.0%	1	14.3%	0
Members not devoting sufficient time	1	33.3%	0	0.0%	0
Members have not built relationships with county supervisors	0	0.0%	1	14.3%	0
Grand Total	**5**		**9**		**7**
Number of Counties Responding	**3**		**7**		**4**

Source: Survey of Local Mental Health Departments

Table 41 on Page 64 shows that 39 percent of the MHB/Cs ranked training on the MHB/C role and responsibilities and on mental health issues as their top recommendation for increasing their effectiveness. The following four recommendations were made by nearly 20 percent of MHB/Cs:

- improve recruitment for qualified members balancing ethnicity and geography;
- increase MHB/C involvement in activities of the local mental health department;
- increase MHB/C efforts to evaluate the system; and
- increase the commitment of MHB/C members through clearer and more effective committee structures.

Table 42 on Page 65 shows the top three recommendations made by local mental health departments for increasing the effectiveness of the MHB/Cs:

- MHB/Cs need basic training on how to function as a board and on the role of MHB/Cs in county and state government (27 percent);
- MHB/Cs need training on specific mental health issues (24 percent); and
- local mental health departments and MHB/Cs must trust each other, communicate effectively, and coordinate their efforts (18 percent).

Mental health directors and MHB/Cs agree that adding more direct consumers and family members to MHB/Cs has increased the effectiveness of boards and commissions. Having hard working, knowledgeable members who are committed to their work is essential. In addition, both the MHB/C and the mental health director must establish a good working relationship. Factors that mitigate against the effectiveness of MHB/Cs relate mostly to lack of training for new, inexperienced members, lack of support and technical assistance for on-going operations, and difficulty recruiting and retaining members. MHB/Cs attribute some of these problems to their loss of a mandated and funded statewide organization. Recommendations made by both groups point to the need for statewide training for MHB/Cs on their role in the mental health system, on how to function as a board, and on specific mental health issues they will have to address.

Resources Available for Training MHB/Cs

At least three entities are in a position to provide training to MHB/Cs:

- California Association of Local Mental Health Boards and Commissions (CALMHB/C)

  After the Organization of Mental Health Advisory Boards was repealed from statute, some of the MHB/Cs began organizing a similar statewide organization to recoup the continuity that had been lost. These MHB/Cs formed the CALMHB/C. At this time, over 50 percent of the MHB/Cs statewide have chosen to belong to this organization. The DMH gave the organization $25,000 to fund travel costs. In terms of training, the CALMHB/C has thus far had one statewide meeting, which is really all its budget will permit. In addition, the CALMHB/C Training Committee has focused on developing a training plan based on regional networking.

- Statewide Training Plan Committee

The DMH convened the Statewide Training Plan Committee to implement WIC Section 4060 and 4061. These provisions established a joint state-county decision-making process to promote effective and efficient quality mental health services under the realigned mental health system through training, consultation, and technical assistance to the mental health system. The DMH then contracted with the CIMH to provide staff support to the Statewide Training Plan Committee. The committee has allocated a portion of the training budget for MHB/C training. It is developing a manual for MHB/Cs and videotapes on the role and responsibility of MHB/Cs. However, these projects have not yet been completed.

Table 41: Recommendations by MHB/Cs for increasing their effectiveness.

	Bay Area		Central		Sout
	Number of Responses	Percent of Counties Responding	Number of Responses	Percent of Counties Responding	Number of Responses
Provide training on MHB/C role and responsibilities and on mental health issues	0	0.0%	5	45.5%	5
Improve recruitment for qualified members, balancing ethnicity and geography	2	25.0%	1	9.1%	3
Increase MHB/C involvement in local mental health department activities	4	50.0%	0	0.0%	2
MHB/Cs should be more active in evaluating the system	3	37.5%	1	9.1%	3
Increase commitment of MHB/C members through clearer goals and effective committee structures	3	37.5%	2	18.2%	2
Provide MHB/C with additional funding and support	3	37.5%	0	0.0%	2
Increase MHB/C communication with local governmental bodies and constituency	1	12.5%	1	9.1%	2
State-level groups should communicate more frequently and effectively with MHB/Cs	2	25.0%	2	18.2%	0
Fill all vacancies	0	0.0%	1	9.1%	2
Increase participation of county supervisor who sits on MHB/C	0	0.0%	2	18.2%	1
Grand Total	**18**		**15**		**22**

Number of Counties Responding	**8**		**11**		**10**

Source: Survey of Mental Health Boards/Commissions

Table 42: Recommendations from local mental health departments for increasing the effectiveness of MHB/Cs.

	Bay Area		Central		Sout
	Number of Responses	Percent of Counties Responding	Number of Responses	Percent of Counties Responding	Number of Responses
MHB/C needs basic training on how to function as board and on role of MHB/C in county & state government	2	25.0%	2	20.0%	2
MHB/C needs training on specific mental health issues	2	25.0%	2	20.0%	1
Departments and MHB/C must trust each other, communicate effectively, and coordinate efforts	4	50.0%	1	10.0%	0
Greater time commitment is required from MHB/C members	1	12.5%	1	10.0%	0
Develop a stronger relationship between the MHB/C and the governing body	0	0.0%	2	20.0%	1
MHB/C members should meet regionally	1	12.5%	0	0.0%	0
Change the statute regarding eligibility to serve on MHB/C	2	25.0%	1	10.0%	1
MHB/C should have enough members to ensure all the work gets done and all aspects of constituency are represented	0	0.0%	1	10.0%	2
Improve the MHB/C's committee structure	0	0.0%	0	0.0%	2
Increase participation of direct consumers	1	12.5%	0	0.0%	1
MHB/C members should participate in statewide meetings	0	0.0%	0	0.0%	0
MHB/C needs training to facilitate effective participation by direct consumers and family members	0	0.0%	0	0.0%	1
Training for MHB/C needs to be accessible and inexpensive.	0	0.0%	0	0.0%	0
Grand Total	**13**		**10**		**11**

Number of Counties Responding	**8**		**10**		**6**

Source: Survey of Local Mental Health Departments

- CMHPC

  The CMHPC is also mandated to assist in the coordination of training and information dissemination to the MHB/Cs to ensure the MHB/Cs can effectively carry out their duties. However, the CMHPC has not allocated any of its limited staff resources to perform this function.

Recommendation

The California Mental Health Planning Council should convene the key mental health stakeholders, including the DMH, MHB/Cs, CALMHB/C, CMHDA, and CIMH to assess whether current efforts to provide training and technical assistance to MHB/Cs are adequate and, if not, how to improve them.

Conclusion

One of the goals of realignment was to transfer the locus of funding, planning, and priority setting for mental health services to the local level. Local mental health departments and governing bodies were given more autonomy and flexibility so they could use their resources to meet the unique needs of their communities. This study indicates that most local mental health departments have manifested these goals of realignment by doing planning for their systems of care and by involving the major stakeholders in local mental health programs. In addition, some governing bodies are becoming more involved in mental health decision making as evidenced by their asking more questions about mental health budget issues at board meetings and participating more with their MHB/Cs.

Although realignment's goals of greater control and involvement in decision making have been partially achieved by local mental health departments and governing bodies, MHB/Cs have had only limited success. The composition and process for appointing MHB/Cs were changed specifically to increase the involvement of direct consumers and family members in the decision-making process and to strengthen the relationship between county supervisors and their appointees. Achieving this goal is being undermined by lack of compliance with the statutory provisions. For example, nearly one-half of MHB/Cs have not had enough direct consumers and family members appointed. In addition, governing bodies are not making appointments that reflect the ethnic diversity of their communities, thereby reducing opportunities for input on the cultural competency of mental health services. Finally, two-thirds of the MHB/Cs have not been appointed according to the process outlined in statute whereby each county supervisor makes an equal number of appointments.

These problems with statutory compliance no doubt compound the difficulties MHB/Cs have in effectively performing their statutory duties. This study reveals that in the majority of counties MHB/Cs have not increased their input on mental health issues to either local mental health departments or governing bodies. Both MHB/Cs and local mental health departments have a clear sense of what factors contribute to the effectiveness and ineffectiveness of MHB/Cs and how to remedy the situation. A consistent source of training and technical support is called for. However, the entities at the state level that could provide such assistance have not done so largely because none have sufficient resources to accomplish the task. The CMHPC should convene a meeting of the parties involved to develop solutions to this problem.

CHAPTER 5

IMPLEMENTATION OF SYSTEM REFORMS FROM THE *CALIFORNIA MENTAL HEALTH MASTER PLAN*

Use of the *Master Plan*

> *In the last part of the 1980's through the Master Plan process, there was a realization by the mental health constituents that we had to build consensus or witness the further erosion of mental health services. Mental health directors, consumers, family members, and providers began to work together to seek solutions which might refocus and hopefully rebuild the deteriorating public mental health system.*
>
> *James Broderick, Ph.D., Director, Shasta County Mental Health Department*
> *Public Hearing: Redding, CA, July 25, 1994*

Chapter 1313, Statutes of 1989, required the PL 99-660 Planning Council to develop a master plan for mental health services that integrated key planning and system reform issues, established priorities for the service delivery system, and analyzed critical policy issues. This report entitled, *California Mental Health Master Plan (Master Plan)*, was issued in October 1991. Because representatives of all major mental health constituency groups developed the *Master Plan*, it was perceived as presenting the consensus of the mental health community concerning a variety of policy issues. The *Master Plan* advocated the principles of client empowerment, established definitions for priority target populations, developed model systems of care for each target population, focused on the importance of culturally competent services, and emphasized the need for system accountability through measurable outcomes. The *Master Plan* was largely incorporated into realignment.

Use by Local Mental Health Departments

Finding

The preponderance of local mental health departments that did planning for their systems of care used the *California Mental Health Master Plan*.

As shown in Table 43, Table 44, and Table 45 on Page 68, approximately 70 percent of local mental health departments that did planning for their systems of care used the *Master Plan*. However, use of the *Master Plan* was consistently higher for all three systems of care in the Bay Area and Central regions. Use of the *Master Plan* in these regions ranged from 75 to 100 percent of local mental health departments whereas use by local mental health departments in the Southern and Superior regions ranged from 50 to 67 percent.

The reasons for this difference are not immediately discernible. Use of the *Master Plan* does not seem to correlate with the size of a county or whether it is urban or rural. Understanding this phenomenon is important, however, because the CMHPC will be updating the *Master Plan* in 1995. Because the aim of the plan is to influence the development of systems of care in each county, making the plan as useful and accessible as possible is important.

Table 43: Do local mental health departments use the *Master Plan* in planning for children's systems of care?

	Yes		No		Statewide	
Region	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Total Number of Counties	Total Percent of Counties
Bay Area	8	88.9%	1	11.1%	9	100.0%
Central	6	85.7%	1	14.3%	7	100.0%
Southern	4	50.0%	4	50.0%	8	100.0%
Superior	4	57.1%	3	42.9%	7	100.0%
Statewide	**22**	**71.0%**	**9**	**29.0%**	**31**	**100.0%**

Source: Survey of Local Mental Health Departments

Table 44: Do local mental health departments use the *Master Plan* in planning for adult systems of care?

	Yes		No		Statewide	
Region	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Total Number of Counties	Total Percent of Counties
Bay Area	7	77.8%	2	22.2%	9	100.0%
Central	7	100.0%	0	0.0%	7	100.0%
Southern	4	50.0%	4	50.0%	8	100.0%
Superior	3	50.0%	3	50.0%	6	100.0%
Statewide	**21**	**70.0%**	**9**	**30.0%**	**30**	**100.0%**

Source: Survey of Local Mental Health Departments

Table 45: Do local mental health departments use the *Master Plan* in planning for older adult systems of care?

	Yes		No		Statewide	
Region	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Total Number of Counties	Total Percent of Counties
Bay Area	6	85.7%	1	14.3%	7	100.0%
Central	3	75.0%	1	25.0%	4	100.0%
Southern	4	50.0%	4	50.0%	8	100.0%
Superior	2	66.7%	1	33.3%	3	100.0%
Statewide	**15**	**68.2%**	**7**	**31.8%**	**22**	**100.0%**

Source: Survey of Local Mental Health Departments

Recommendation

Prior to revising the *Master Plan*, the CMHPC should contact local mental health departments that used the *Master Plan* to determine what aspects were the most useful. In addition, the CMHPC should make a special effort to contact local mental health departments that did not use the *Master Plan* to determine what prevented them from using it and what would make it more useful to them.

Use by Mental Health Boards/Commissions

Finding

Most MHB/Cs are either unaware of the *Master Plan* or do not find it helpful to their planning efforts.

Table 46 on Page 70 reveals that 34 percent of MHB/Cs statewide used the *Master Plan* in their local planning efforts. However, 40 percent of MHB/Cs are not familiar with the *Master Plan*. The lack of familiarity with the *Master Plan* is most likely due to all the new MHB/C members that have been appointed in the past several years. The *Master Plan* was published in October 1991, and the statute reforming the MHB/Cs and triggering new appointments did not go into effect until October 1992. In some cases, the reported lack of familiarity may be due to different names used for the *Master Plan*. Because the plan was developed pursuant to AB 904, some refer to it as the "AB 904 Plan."

Of the 60 percent that are familiar with the Master Plan, approximately 20 percent report it was not helpful to them for a variety of reasons. For example, two MHB/Cs in the Superior region did not use the *Master Plan* because they felt it was not relevant to rural counties, and one MHB/C in the Bay Area did not use the *Master Plan* because they felt it was not relevant to urban areas. Two other MHB/Cs reported that lack of funding prevented them from implementing the range of services recommended in the *Master Plan*. Finally, two other MHB/Cs felt that the *Master Plan* did not address local needs.

Many MHB/Cs are either unaware of the *Master Plan* or choose not to use it. This situation is counterproductive because the *Master Plan* was designed to assist local mental health programs in developing their systems of care in directions consistent with the *Master Plan's* system reform goals enacted in statute.

Recommendation

- The CMHPC should contact those MHB/Cs that did not find the *Master Plan* helpful to obtain their suggestions about how it should be modified to meet their needs.
- Prior to distributing the revised *Master Plan*, the CMHPC should provide training to all MHB/Cs to familiarize them with the *Master Plan*, its purpose, and the potential benefits of using it.

Client and Family Member Empowerment and Involvement

> *The changes in the decision-making process at the local level have resulted in more input to decision making by family members and direct consumers. Specifically, realignment has created an emphasis on client-directed services in our agency, which has allowed staff members greater flexibility in serving consumers and family members.*
>
> *Kevin Albrigo, Merced County Mental Health Department*
> *and Alliance for the Mentally Ill of Merced County*
> *Public Hearing: Fresno, CA, August 22, 1994*

Client-centered Approach

The *California Mental Health Master Plan* developed the mission for the State's mental health system and the philosophy of providing services in systems of care that was enacted in the realignment legislation. Together these provisions describe the client-centered approach that is supposed to be the cornerstone of this State's mental health system. WIC Section 5600.1 states that the mission of the mental health system "shall be to enable seriously mentally disabled persons of all ages to access services and programs that assist them, in a manner tailored to each individual, to manage their illness, to achieve their own personal goals, and to develop skills and supports leading to a constructive and more satisfying life in the least restrictive available setting."

Table 46: Have MHB/Cs used the *Master Plan* in local planning?

	Bay Area		Central		South
	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Number of Counties
Not familiar with *Master Plan*	5	41.7%	6	42.9%	3
Not engaged in local planning	0	0.0%	1	7.1%	0
Did not use *Master Plan* in developing local plan	1	8.3%	1	7.1%	0
Master Plan not relevant to rural counties	0	0.0%	0	0.0%	0
Master Plan not relevant to 100% urban counties	1	8.3%	0	0.0%	0
Use of *Master Plan* hampered by lack of funding for services	0	0.0%	1	7.1%	1
Master Plan does not address local needs	1	8.3%	0	0.0%	1
Used *Master Plan* in development of local plan	0	0.0%	0	0.0%	1
Master Plan useful for system of care framework	1	8.3%	1	7.1%	1
Master Plan guided MHB/C to increase participation of direct consumers	1	8.3%	1	7.1%	0
Master Plan helped to identify gaps in services and to prioritize services	1	8.3%	2	14.3%	0
Master Plan served as a model for local plan	1	8.3%	1	7.1%	2
Grand Total	**12**	**100.0%**	**14**	**100.0%**	**9**

Source: Survey of Mental Health Boards/Commissions

WIC Section 5600.2(a) indicates that "public mental health services in this state should be provided...in systems of care that are client-centered...and fully accountable...." It details the client-centered approach:

> Persons with mental disabilities:
>
> (1) Retain all the rights, privileges, opportunities, and responsibilities of other citizens unless specifically limited by federal or state law or regulations.
>
> (2) Are the central and deciding figures, except where specifically limited by law, in all planning for treatment and rehabilitation based on their individual needs. Planning should also include family members and friends as a source of information and support.
>
> (3) Shall be viewed as total persons and members of families and communities. Mental health services should assist clients in returning to the most constructive and satisfying lifestyles of their own definition and choice.
>
> (4) Should receive treatment and rehabilitation in the most appropriate and least restrictive environment, preferably in their own communities.
>
> (5) Should have an identifiable person or team responsible for their support and treatment.
>
> (6) Shall have available a mental health advocate to ensure their rights as mental health consumers pursuant to Section 5521.

Involvement of Direct Consumers and Family Members in Policy Development

Realignment might be said to be the first step in the democratization of the mental health system. The process is slow, and we have a long way to go in implementing realignment. If we are going to include consumers as decision makers and as critical parts of the decision-making process in the mental health system, then we are setting them up for failure if we do not provide consumers with adequate training. Training is an important issue that needs to be addressed statewide.

Patrick Moriarity, Executive Director, Stillwater Learning Program
Public Hearing: Redding, CA, July 25, 1994

Finding

Local mental health departments have begun to involve direct consumers and family members in planning for local mental health programs.

In addition to the principles of the client-centered approach in statute, the *California Mental Health Master Plan* elaborates on empowering clients. It states, "Persons with mental disabilities shall also be actively involved in all aspects of policymaking, planning, and delivering services." The *Master Plan* also posits that family members "shall...be consulted...in planning, operating, and evaluating the mental health system."

Realignment enacted a number of changes to give local mental health departments more flexibility in designing local programs to meet the unique needs of their communities. One aim of this increased flexibility was to enable local mental health departments to be more responsive to key constituents, such as direct consumers and family members. An unduplicated count of the local mental health departments responding to the survey reveals that these activities are underway in 21 counties, 37

percent. Table 47 reports on specific ways that local mental health departments have increased their responsiveness:

- 16 percent of the departments report that they are involving direct consumers and family members in developing specific programs the departments have initiated;
- 9 percent report they are developing programs in response to requests from direct consumers and family members;
- 15 percent indicate they are involving direct consumers and family members in system planning through membership in department committees; and
- 6 percent report they included direct consumers and family members in decisions about budget cuts and funding shifts.

Reviewing Table 48 on Page 75 reveals that 25 percent of MHB/Cs believe local mental health departments are developing programs that are more responsive to local needs. MHB/Cs also report the same types of actions by local mental health departments to empower direct consumers and family members at approximately the same rates that the departments themselves report.

Table 47 and Table 48 also show that approximately one third of local mental health departments and MHB/Cs believe that realignment has not changed the responsiveness of local mental health departments to direct consumers and their families. These responses, however, may be an artifact of the construction of the questions. Seven percent of the departments wrote in their surveys that they have always been very responsive to direct consumers and family members and that realignment did not change their behavior. Some of the other local mental health departments responding "No change" may also have meant they were always responsive, but the extent to which that is true is unknown.

The concept of empowerment has probably not spread further due to inertia and resistance to change. This type of empowerment can cause the decisions of local mental health departments to be challenged. Being reluctant to put oneself in a position to be challenged is understandable. In addition, some mental health directors have expressed frustration at the difficulty of finding direct consumers able to advise on policymaking. Even members of MHB/Cs are not always sufficiently conversant with the operation of the local mental health program or techniques for advocacy to enable them to advise local mental health departments effectively. The limited implementation of consumer and family member empowerment means that a client-driven system is not being fully realized. Local mental health departments, direct consumers, and family members would all benefit from implementation of this empowerment concept.

Recommendation

- The Statewide Training Plan Committee should include another round of empowerment workshops in a future training plan. These workshops should build on the previous empowerment workshops and focus on the benefits of collaboration. The target audience would be all groups party to the collaboration: local mental health departments, MHB/Cs, direct consumers, and family members.
- Focused training should be provided to direct consumers and family members in each county to enable them to be effective participants in department committees and task forces. This training should provide information about how local mental health departments operate, including budgeting and planning. Such training should help direct consumers and family members be effective advocates so that local mental health departments and governing bodies solicit their participation.
- To increase the pool of direct consumers available to participate in local mental health policymaking, mental health programs should enlist the aid of clinical staff and discharge planners at mental health facilities. These staff could inform direct consumers about the local

mental health department's interest in empowering consumers to be involved in policymaking and could inform them of any training and advocacy opportunities.

Table 47: Do local mental health departments believe that the increased flexibility provided by realignment has enabl

	Bay Area		Central		Soutl
	Number of Responses	Percent of Counties Responding	Number of Responses	Percent of Counties Responding	Number of Responses
No change	2	16.7%	7	41.2%	4
Involving direct consumers and family members in developing specific programs initiated by department	3	25.0%	2	11.8%	2
Involving direct consumers and family members in system planning through department committees	3	25.0%	3	17.6%	0
Developing more community-based programs with rehabilitation focus	1	8.3%	2	11.8%	1
Developing programs in response to requests from direct consumers and family members	1	8.3%	1	5.9%	2
Flexibility in realignment funding enabled departments to create more community-based programs with rehabilitation focus	3	25.0%	0	0.0%	1
Included direct consumers and family members in decisions about budget cuts and funding shifts	0	0.0%	1	5.9%	1
Local mental health departments have always been responsive	1	8.3%	0	0.0%	1
Realignment has facilitated more responsiveness	1	8.3%	2	11.8%	0
Insufficient funding inhibits responsiveness	0	0.0%	2	11.8%	0
Grand Total	**15**		**20**		**12**

Number of Counties Responding	**12**		**17**		**10**

Source: Survey of Local Mental Health Departments

Table 48: Do MHB/Cs believe that the increased flexibility provided by realignment has enabled local mental health c consumers and their families?

	Bay Area		Central		Sout
	Number of Responses	Percent of Counties Responding	Number of Responses	Percent of Counties Responding	Number of Responses
No change in responsiveness	3	25.0%	5	35.7%	1
Departments developing programs more responsive to local needs	1	8.3%	2	14.3%	4
Departments involving consumers and family members more on committees	4	33.3%	1	7.1%	0
Departments developed or expanded self-help program	2	16.7%	1	7.1%	1
Departments giving housing issues higher priority	1	8.3%	1	7.1%	1
Departments developing programs at request of consumers/family members	0	0.0%	1	7.1%	2
Departments are more responsive	0	0.0%	1	7.1%	0
Departments returning clients from out-of-county placements	1	8.3%	1	7.1%	0
Departments appointed direct consumer/family member advocates	0	0.0%	0	0.0%	2
Departments hiring more direct consumers	0	0.0%	0	0.0%	1
Departments have established a grievance procedure	0	0.0%	0	0.0%	0
Responsiveness hindered by revenue shortfall	0	0.0%	1	7.1%	0
Responsiveness hindered by narrow target population definitions	1	8.3%	0	0.0%	0
Do not know	1	8.3%	1	7.1%	1
Grand Total	**14**		**15**		**13**
Number of Counties Responding	**12**		**14**		**10**

Source: Survey of Mental Health Boards/Commissions

- The California Network of Mental Health Clients and the California Alliance for the Mentally Ill should educate their members on the advantages of direct participation in task forces and committees established by local mental health departments.
- CMHDA leadership should emphasize in its policies and model for its directors the importance of involving direct consumers and family members in policymaking. Possibly, a series of presentations at its statewide meetings showcasing local mental health departments whose programs have benefited from collaboration among the departments, direct consumers, and family members would foster more inclusive decision-making methods.
- The CMHPC should also include presentations on empowerment and collaboration at its statewide meetings.

Employment of Direct Consumers and Family Members

Direct Consumers

Finding

Although local mental health programs have posted significant percentage increases in employment of direct consumers, the total number of direct consumers employed remains small.

The *California Mental Health Master Plan* recommends that "programs shall be developed to employ clients. Mental health clients working in the mental health system can bring a special quality to those they work with because they contribute their own experiences as clients."

Table 49 on Page 77 reveals that 44 percent of local mental health departments have established goals in county-operated programs for hiring direct consumers. Of that 44 percent, 22 percent have hired a specific number of direct consumers or established a numeric goal for hiring, and another 15 percent have established a general goal to hire direct consumers. Regionally, 53 to 67 percent of the local mental health departments in the Bay Area, Central, and Southern regions have established goals to hire direct consumers in county-operated programs. In the Superior region, only 6 percent of the local mental health departments have established hiring goals. However, an additional 12 percent of the departments in that region are developing plans for hiring direct consumers.

Table 50 on Page 77 shows that 20 percent of local mental health departments have established hiring goals for their contract agencies. These local mental health departments have either required that contractors employ some amount of direct consumers or established a general goal for hiring them. The Bay Area leads other regions in requiring contractors to hire direct consumers. In that region, 67 percent of local mental health departments established goals for contractors to hire direct consumers. No local mental health departments in the Superior region require contractors to hire direct consumers. However, most programs in the Superior region are county operated, which accounts for this condition. In the Central region, only 6 percent of local mental health departments require contractors to hire direct consumers; and in the Southern region, 18 percent have a requirement.

Table 51 on Page 78 summarizes the employment of direct consumers in county-operated and contract agencies since FY 1990-91. Overall, employment of direct consumers has increased nearly 400 percent with county-operated programs increasing 529 percent and contract agencies increasing 367 percent. In absolute numbers, contract agencies employ more direct consumers than do county-operated programs. For FY 1993-94, local mental health departments reported that they employed 120 direct consumers compared with the 439 that they reported their contract agencies employ.

Table 49: Have local mental health departments established goals for hiring direct consumers in county-opera

	Bay Area		Central		Soutl
	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Number of Counties
Have not established goals	2	16.7%	8	47.1%	4
Have hired direct consumers and established specific numeric goals	6	50.0%	3	17.6%	2
Established general goal to hire direct consumers	1	8.3%	5	29.4%	2
Each new and vacant position reviewed for possibility of hiring direct consumer	1	8.3%	1	5.9%	2
Developing plans for hiring direct consumers	2	16.7%	0	0.0%	0
Grand Total	**12**	**100.0%**	**17**	**100.0%**	**10**

Source: Survey of Local Mental Health Departments

Table 50: Have local mental health departments established goals for hiring direct consumers in contract ager

	Bay Area		Central		Sout
	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Number of Counties
No goals established	3	25.0%	16	94.1%	9
Contractors required to employ some direct consumers	2	16.7%	1	5.9%	2
Established a general goal that contractors should employ direct consumers	6	50.0%	0	0.0%	0
Encourage contractors to hire direct consumers	1	8.3%	0	0.0%	0
Grand Total	**12**	**100.0%**	**17**	**100.0%**	**11**

Source: Survey of Local Mental Health Departments

Table 51: Employment of direct consumers in local mental health programs for FY 1990-91 through FY 1993-

	FY 1990-91	FY 1991-92	Change between FY 1990-91 and FY 1991-92		FY 1992-93	Change between FY 1991-92 and FY 1992-93	
Region	# of Direct Consumers	# of Direct Consumers	Change in #	Percent Change	# of Direct Consumers	Change in #	Percent Change
County-operated Programs							
Bay Area	4	8	4	100.0%	26	18	225.0%
Central	5	6	1	20.0%	7.5	1.5	25.0%
Southern	1	3	2	200.0%	16	13	433.3%
Superior	9	9	0	0.0%	12	3	33.3%
Subtotal	19	26	7	36.8%	61.5	35.5	136.5%
Contract Agencies							
Bay Area	39	48	9	23.1%	74	26	54.2%
Central	7	9	2	28.6%	10	1	11.1%
Southern	45	50	5	11.1%	64	14	28.0%
Superior	3	2	-1	-33.3%	3	1	50.0%
Subtotal	94	109	15	16.0%	151	42	38.5%
Grand Total	**113**	**135**	**22**	**19.5%**	**212.5**	**77.5**	**57.4%**

Source: Survey of Local Mental Health Departments

Table 52: Use of direct consumers as volunteers in local mental health programs for FY 1990-91 through FY 1

	FY 1990-91	FY 1991-92	Change between FY 1990-91 and FY 1991-92		FY 1992-93	Change between FY 1991-92 and FY 1992-93	
Region	# of Direct Consumers	# of Direct Consumers	Change in #	Percent Change	# of Direct Consumers	Change in #	Percent Change
County-operated Programs							
Bay Area	21	38	17	81.0%	57	19	50.0%
Central	89	84.5	-4.5	-5.1%	134.5	50	59.2%
Southern	5	7	2	40.0%	25	18	257.1%
Superior	3	17	14	466.7%	25	8	47.1%
Subtotal	118	146.5	28.5	24.2%	241.5	95	64.8%
Contract Agencies							
Bay Area	18	31	13	72.2%	37	6	19.4%
Central	6	6	0	0.0%	10	4	66.7%
Southern	23	21	-2	-8.7%	22	1	4.8%
Superior	2	4	2	100.0%	5	1	25.0%
Subtotal	49	62	13	26.5%	74	12	19.4%
Grand Total	**167**	**208.5**	**41.5**	**24.9%**	**315.5**	**107**	**51.3%**

Source: Survey of Local Mental Health Departments

Although the percentage increase in employment of direct consumers in county-operated programs seems dramatic, it is an increase from a very small base. For example, the 529 percent increase in employment of direct consumers from FY 1990-91 to FY 1993-94 is actually an increase of 101 direct consumers from the 19 employed in FY 1990-91 to the 120 employed in FY 1993-94. However, the proportion of direct consumers in the county mental health work force certainly grew at a more rapid pace than the county mental health work force as a whole.

Some of the increase may be attributable to incomplete reporting in the early years of realignment. Local mental health departments and contract agencies were having to reconstruct staffing data going back four years. Some local mental health departments were not able to provide data for the earlier period. However, isolating the two most recent years also reveals gains in employment of direct consumers. From FY 1992-93 to FY 1993-94, overall employment of direct consumers increased by 346 persons, a 163 percent increase. Employment in county-operated programs increased by 58 persons, 94 percent, and in contract agencies by 288, a 191 percent increase.

The use of direct consumers as volunteers is another indicator of the interest of local mental health programs in involving direct consumers in their service systems. Table 52 on Page 78 shows that both county-operated programs and contract agencies have increased their use of direct consumers. The number of direct consumers volunteering in county-operated programs increased from 118 in FY 1990-91 to 291 in FY 1993-94, a 147 percent increase. Contract agencies increased their use of direct consumers as volunteers from 49 in FY 1990-91 to 320 in FY 1993-94, a 553 percent increase.

A clear correlation does not seem to exist between establishing hiring goals and the outcome of hiring a significant number of direct consumers. For example, many more local mental health departments established requirements for county-operated programs to hire direct consumers than established goals for their contract agencies. Yet, contract agencies have hired a larger number of direct consumers than have county-operated programs. One reason that the requirement for hiring direct consumers has not translated into hiring significant numbers is that many of those local mental health departments established a modest goal of hiring at least one direct consumer for each county-operated program.

Without having hiring goals imposed on them by many local mental health departments, contract agencies have hired three times as many direct consumers as have county-operated programs. The argument might be made that contract agencies have greater flexibility because their personnel decisions do not operate within the constraints of the county civil service system. However, civil service requirements in local mental health departments do not appear to be a barrier to hiring direct consumers. Table 53 indicates that 71 percent of the departments that have established hiring goals did not have to modify their civil service requirements. Even if local mental health departments have not had to modify their civil service requirements, civil service systems can still mitigate against hiring direct consumers. For example, in county governments that have had to lay off personnel, lay-off lists are established. Local mental health departments that are able to fill vacant positions must first hire from the lay-off lists. This procedure reduces the opportunity to hire direct consumers.

Table 53: Have local mental health departments that established goals for hiring direct consumers had to modify civil service requirements to accomplish those goals?

	Did not make modifications		Modified civil service classifications and minimum qualifications		Modifications being considered			
Region	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Total Number of Counties	Total Percent of Counties
Bay Area	7	70.0%	0	0.0%	3	30.0%	10	100.0%
Central	6	66.7%	2	22.2%	1	11.1%	9	100.0%
Southern	4	66.7%	1	16.7%	1	16.7%	6	100.0%
Superior	3	100.0%	0	0.0%	0	0.0%	3	100.0%
Statewide	**20**	**71.4%**	**3**	**10.7%**	**5**	**17.9%**	**28**	**100.0%**

Source: Survey of Local Mental Health Departments

The effect of all these factors on the employment of direct consumers is that statewide only 7.8 direct consumers are employed per county when the total number of direct consumers employed in FY 1993-94, 446, is averaged among the 57 local mental health departments responding to this survey. As a result, the advantages of employing direct consumers envisioned in the *Master Plan* are not realized. Clients receiving services are not able to benefit from the experiences of direct consumers who could be hired to help provide treatment. However, with the implementation of the Rehabilitation Option for Medi-Cal reimbursement, opportunities for employing direct consumers should increase. The Rehabilitation Option includes paraprofessionals among the staff that can bill for Medi-Cal.

Recommendation

- The DMH, CMHPC, CMHDA, and other key stakeholders should develop an action plan to increase the employment of direct consumers in mental health programs. The action plan should describe the full range of roles for direct consumers as professionals and paraprofessionals in local mental health programs. In addition, the action plan should evaluate whether barriers exist in county-operated programs and contract agencies to hiring direct consumers and should develop recommendations to eliminate those barriers. It should also examine the potential of the Rehabilitation Option to increase employment of direct consumers.
- The California Network of Mental Health Clients should organize direct consumers working for mental health programs, catalogue the achievements and contributions of these staff, and use this information to promote hiring greater numbers of direct consumers.

Family Members

Finding

Very few local mental health departments have established goals for hiring family members.

Table 54 on Page 82 indicates that 81 percent of local mental health departments have not established goals for hiring family members in county-operated programs. As revealed in Table 55 on Page 82, no departments have established goals for contract agencies to hire family members. The local mental health departments in the Bay Area and Southern regions lead the rest of the State in establishing goals for hiring family members in county-operated programs. Over 30 percent of the local mental health departments in those regions have hiring goals. In the Central region, 7 percent have

established goals, and in the Superior region no local mental health department has established such goals.

The position of family advocate is an emerging trend in county hiring. Although only 2 local mental health departments have established such a position, another 5 departments plan to establish a family advocate position. In addition, another 2 departments are developing plans for hiring family members.

Availability of Self-help Services

Realignment has been a positive force in sanctioning the philosophy of client-directed services in general, helping our county win a grant for self-help and employment of consumers/survivors.

Kevin Albrigo, Merced County Mental Health Department
and Alliance for the Mentally Ill of Merced County
Public Hearing: Fresno, CA, August 22, 1994

Table 54: Have local mental health departments established goals for hiring family members in county-operat

	Bay Area		Central		South
	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Number of Counties
Have not established goals	6	54.5%	14	93.3%	7
Established family advocate position	0	0.0%	1	6.7%	1
Plan to establish family advocate position	3	27.3%	0	0.0%	2
Each new and vacant position reviewed for possibility of hiring family member	1	9.1%	0	0.0%	0
Developing plans for hiring family members	1	9.1%	0	0.0%	0
Grand Total	**11**	**100.0%**	**15**	**100.0%**	**10**

Source: Survey of Local Mental Health Departments

Table 55: Have local mental health departments established goals for hiring family members in contract agenc

	Bay Area		Central		South
	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Number of Counties
No goals established	**11**	**100.0%**	**17**	**100.0%**	**11**

Source: Survey of Local Mental Health Departments

Finding

The availability of self-help programs has increased in over 40 percent of local mental health programs.

WIC Section 5600.2(i) states that the mental health system should promote the development and use of self-help groups by persons with serious mental illnesses so that these groups will be available in all areas of the State. The *California Mental Health Master Plan* recommends, "Service systems shall incorporate client self-help approaches."

Table 56 on Page 84 shows that 42 percent of local mental health departments have increased the availability of self-help programs for direct consumers. This statewide figure, however, masks regional differences. The largest increases in availability of self-help programs occurred in the Bay Area and Southern regions, increasing 58 and 55 percent, respectively. The increase in self-help programs may be more pronounced in those two regions because of their urban nature. Developing self-help programs in smaller, rural counties is more challenging because sufficient concentrations of direct consumers do not exist. Moreover, geography and transportation problems in rural counties work against the formation of self-help groups.

Priority Target Populations

Finding

The proportion of clients who meet the definitions for target populations served by local mental health programs increased more prior to the implementation of realignment than it did afterwards.

The *Master Plan* advocated giving highest priority for services to adults with serious mental illnesses and children and adolescents with serious emotional disturbances. Realignment resulted in enacting WIC Section 5600.3, which specified that the primary goal for the use of realignment funds should be to serve the following target populations:

- seriously emotionally disturbed children and adolescents;
- adults and older adults who have a serious mental disorder;
- adults or older adults who require or are at risk of requiring acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention because of a mental disorder with symptoms of psychosis, suicidality, or violence; and
- persons who need brief treatment as a result of a natural disaster or severe local emergency.

The data indicate that most local mental health departments began shifting their services to the target population prior to realignment although the proportion of target population clients served has still continued to grow after realignment. This trend prior to the enactment of the target population statute most likely resulted from the reduction in resources that had been occurring for the last decade prior to realignment. Defining target populations in the realignment legislation simply codified what was already taking place in the local mental health programs.

The DMH's Statistics Section provided the data used to analyze this issue. The Statistics Section compiled data from FY 1986-87 through FY 1992-93 showing the number and percentage of persons with major functional disorders being served in the mental health system in relationship to the entire client population. "Major functional disorder" was determined based on diagnoses from the DSM III-R and the International Code of Diseases 9. These diagnoses included schizophrenia, mood disorders, and other psychotic disorders. This definition was also tailored to comply with the definition for target populations established in statute for children and youth, adults, and older adults.

Table 56: Has the availability of self-help services increased since realignment?

	Bay Area		Central		Sout
	Number of Responses	Percent of Counties Responding	Number of Responses	Percent of Counties Responding	Number of Responses
No change in availability	4	33.3%	10	55.6%	5
Availability has increased	0	0.0%	1	5.6%	0
Added or expanded self-help programs for direct consumers	7	58.3%	5	27.8%	6
Hired professional staff to coordinate self-help program	0	0.0%	1	5.6%	0
Added or expanded senior peer counseling programs	1	8.3%	1	5.6%	0
Established self -help programs for family members	0	0.0%	1	5.6%	0
Grand Total	**12**		**19**		**11**
Number of Counties Responding	**12**		**18**		**11**

Source: Survey of Local Mental Health Departments

In addition to the data on the number of clients with major functional disorders, the DMH also provided the adjusted gross cost for services provided to clients with major functional disorders and percentage of that adjusted gross cost in relationship to the total adjusted gross cost statewide. "Adjusted gross cost" is the entire cost of providing direct services plus county overhead.

Table 57 on Page 86 shows that 165,382, 51.5 percent, of the 321,032 clients served statewide in FY 1986-87 had major functional disorders. In FY 1992-93, local mental health programs served 204,554 clients with major functional disorders out of 333,463 clients served statewide. The proportion of clients with major functional disorders served that year was 61.3 percent, a 9.8 percent increase over FY 1986-87. From FY 1986-87 to FY 1990-91, the years prior to realignment, the increase in the proportion of clients with major functional disorders was 7.6 percent. In contrast, the increase from FY 1990-91 to FY 1992-93, the years after realignment, was only 2.2 percent.

Table 57 also shows that clients with major functional disorders served in FY 1986-87 used 70 percent of the total adjusted gross cost statewide. This figure increased to 76.1 percent in FY 1992-93. The difference from FY 1986-87 to FY 1992-93 was a percentage increase of 6.1 percent. The difference from FY 1986-87 to FY 1990-91, pre-realignment years, was 3.5 percent; and the difference from FY 1990-91 to FY 1992-93, post-realignment years, was 2.6 percent.

The proportion of funds spent on persons in the target population increased by 6.1 percent. Yet, the proportion of individuals served increased by 9.8 percent. Why would the proportion of target population served experience more growth than the adjusted gross cost spent on services for clients in the target population? Local mental health departments have a portion of their budget that must be spent on assessing the mental health status of each client presenting for treatment regardless of whether the person is a member of the target population. This factor primarily accounts for difference. In addition, local mental health departments must provide costly inpatient services to anyone placed on involuntary holds. As a result, a portion of the mental health budget is unavailable for reallocation. This factor placed constraints on the amount of funds that local mental health departments could shift to serve clients in the target population.

Table 58 on Page 87 analyzes how the change in the proportion of target population clients served was manifested by local mental health departments. Data for this table was obtained by calculating for each county the change in the proportion of clients with major functional disorders for two periods: FY 1986-87 to FY 1990-91 (pre-realignment) and FY 1990-91 to FY 1992-93 (post-realignment). Then, each county was classified into the following categories:

- whether the proportion of persons served with major functional disorders increased more before realignment;
- whether the increase in the proportion of persons served with major functional disorders was nearly equal before and after realignment. "Nearly equal" means the change in proportion of target population clients served before and after realignment was within two percentage points.
- whether the proportion of persons served with major functional disorders increased more after realignment; or
- whether the proportion of persons served with major functional disorders decreased from FY 1986-87 to FY 1992-93.

Table 58 shows that in 63 percent of the local mental health programs the proportion of clients served with major functional disorders increased more before realignment. In only 22 percent of the local mental health programs did the proportion of clients served with major functional disorders increase more after realignment. In 10 percent of the programs, the proportion of clients served with major functional disorders increased nearly as much before realignment as after. In 5 percent of the local mental health programs, the proportion of clients served with a major functional disorder actually decreased from FY 1986-87 to FY 1992-93.

Table 57: Proportion of clients with major functional disorders and adjusted gross cost of those services for FY 1986-

	Total Number of Clients	Total Number of Clients with Major Functional Disorders	Percent of Clients with Major Functional Disorders
FY 1986-87	321,032	165,382	51.5
FY 1987-88	328,078	175,440	53.5
Difference: FY 1986-87 to FY 1987-88	7,046	10,058	2.0
FY 1988-89	324,780	182,179	56.1
Difference: FY 1987-88 to FY 1988-89	-3,298	6,739	2.6
FY 1989-90	316,392	181,731	57.4
Difference: FY 1988-89 to FY 1989-90	-8,388	-448	1.3
FY 1990-91	318,899	188,441	59.1
Difference: FY 1989-90 to FY 1990-91	2,507	6,710	1.7
FY 1991-92	331,282	197,940	59.8
Difference: FY 1990-91 to FY 1991-92	12,383	9,499	0.7
FY 1992-93	333,463	204,554	61.3
Difference: FY 1991-92 to FY 1992-93	2,181	6,614	1.5
Difference: FY 1986-87 to FY 1990-91	-2,133	23,059	7.6
Difference: FY 1990-91 to FY 1992-93	14,564	16,113	2.2
Difference: FY 1986-87 to FY 1992-93	**12,431**	**39,172**	**9.8**

Source: State Department of Mental Health Client Data System

Table 58: Change in number of clients served with a major functional disorder before and after realignment.

	Bay Area		Central		Sout
	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Number of Counties
Percent of clients served increased more before realignment	8	61.5%	10	55.6%	8
Percent increase in clients served nearly equal before and after realignment	3	23.1%	1	5.6%	1
Percent of clients served increased more after realignment	2	15.4%	6	33.3%	0
Percent of clients with major functional disorders served decreased from FY 1986-87 to FY 1992-93	0	0.0%	1	5.6%	2
Grand Total	**13**	**100.0%**	**18**	**100.0%**	**11**

Source: State Department of Mental Health Client Data System

Table 59: Change in adjusted gross cost for services to clients with a major functional disorder before and after realig

	Bay Area		Central		Sout
	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Number of Counties
Percent adjusted gross cost increased more before realignment	5	38.5%	8	44.4%	7
Percent increase in adjusted gross cost nearly equal before and after realignment	5	38.5%	1	5.6%	1
Percent adjusted gross cost increased more after realignment	2	15.4%	6	33.3%	1
Percent adjusted gross cost for svcs. to clients with major functional disorders decreased from FY 86-87 to FY 92-93	1	7.7%	3	16.7%	2
Grand Total	**13**	**100.0%**	**18**	**100.0%**	**11**

Source: State Department of Mental Health Client Data System

Table 59 on Page 87 shows that in slightly over half of the local mental health programs the adjusted gross cost of services for clients with major functional disorders increased more before realignment.[10] In 12 percent of the local mental health programs, the adjusted gross cost increased nearly as much before realignment as after, and in 20 percent of the programs it increased more after realignment. In 12 percent of the local mental health programs, the proportion of adjusted gross cost spent on clients with major functional disorders decreased from FY 1986-87 to FY 1992-93.

Providing Services in Systems of Care

> *For the first time in California's history, there could be a system of care for the mentally ill which coordinated state hospitals, Institutions of Mental Disease, and community-based programs. The ability to coordinate services is one of realignment's greatest opportunities.*
>
> *James Broderick, Ph.D., Director, Shasta County Mental Health Department*
> *Public Hearing: Redding, CA, July 25, 1994*

> *Realignment allowed Sacramento County Mental Health Department to restructure its mental health delivery system....Sacramento County redirected resources from state hospitals and IMDs and moved 100 clients from these locked facilities to community Integrated Service Agency programs.*
>
> *Tom Sullivan, Director, Sacramento County Mental Health Department*
> *Public Hearing: Sacramento, CA, June 23, 1994*

Conversion of IMD and State Hospital Resources

Finding

The resource flexibility provisions of realignment enabled local mental health departments to convert their state hospital and IMD resources into uses that better meet local needs.

One of the goals of realignment was to increase the flexibility of resources provided to local mental health departments by converting state hospital and IMD bed allocations to funds so that local mental health departments could use all their resources to better meet local needs. When the provisions of realignment were being crafted, "better meeting local needs" was conceived of as converting institutional resources into community-based resources. Data in this study indicate such actions did occur. However, due to the revenue shortfall in realignment funds and counties' need to reduce spending accordingly, "better meeting local needs" also has come to mean that local mental health departments could choose to reduce spending by cutting back on institutional resources rather than having to reduce community-based programs. In fact, several local mental health departments responded in their surveys that this resource conversion aspect of realignment allowed them to preserve community-based resources in the face of reduced funding.

Table 60 and Table 61 show the extent to which local mental health departments converted state hospital and IMD resources. In FY 1992-93 and FY 1993-94, over 50 percent of local mental health departments converted state hospital resources into other uses. In FY 1992-93, 25 percent of the

[10] Data for Table 59 was obtained by calculating for each county the change in the proportion of adjusted gross cost spent on clients with major functional disorders for two periods: FY 1986-87 to FY 1990-91 and FY 1990-91 to FY 1992-93. Then, each county was classified into the same categories described for Table 58.

departments converted IMD resources into other uses, and 32 percent converted IMD resources in FY 1993-94.

Table 60: Local mental health departments converting state hospital resources in FY 1992-93 and FY 1993-94.

Region	Number of Counties Converting in FY 1992-93	Percent of Counties Converting in FY 1992-93	Number of Counties Converting in FY 1993-94	Percent of Counties Converting in FY 1993-94	Number of Counties Responding to Survey
Bay Area	10	83.3%	11	91.7%	12
Central	7	38.9%	7	38.9%	18
Southern	4	36.4%	7	63.6%	11
Superior	8	50.0%	7	43.8%	16
Statewide	29	50.9%	32	56.1%	57

Source: Survey of Local Mental Health Departments

Table 61: Local mental health departments converting IMD resources in FY 1992-93 and FY 1993-94.

Region	Number of Counties Converting in FY 1992-93	Percent of Counties Converting in FY 1992-93	Number of Counties Converting in FY 1993-94	Percent of Counties Converting in FY 1993-94	Number of Counties Responding to Survey
Bay Area	6	50.0%	6	50.0%	12
Central	4	22.2%	6	33.3%	18
Southern	1	9.1%	1	9.1%	11
Superior	3	18.8%	5	31.3%	16
Statewide	14	24.6%	18	31.6%	57

Source: Survey of Local Mental Health Departments

Differences emerge when analyzing the data on a regional basis. In FY 1992-93, over 80 percent of local mental health departments in the Bay Area and 50 percent of the departments in the Superior region converted state hospital resources compared with under 40 percent of the local mental health departments in the Central and Southern regions. In FY 1993-94, over 90 percent of the departments in the Bay Area converted state hospital resources followed by 64 percent of the departments in the Southern region, 44 percent in the Superior region, and 39 percent in the Central region.

A much smaller proportion of local mental health departments converted IMD resources, but regional differences still exist. In both FY 1992-93 and FY 1993-94, the Bay Area had the highest rate of conversion of IMD resources with 50 percent of local mental health departments doing so. The Southern region had the lowest rate with only 9 percent of the departments converting IMD resources both years.

Table 62 on Page 90 reveals that nearly 74 percent of county supervisors surveyed believe that the flexibility to decategorize mental health resources, such as state hospital and IMD beds, has helped counties be more responsive to local needs. Only 7 percent of the county supervisors believe that the flexibility has not helped. Nineteen percent of the county supervisors believe that the flexibility has not produced the desired results for a variety of reasons. Seven of those county supervisors felt that inadequate funding for the mental health system prevented realignment's flexibility from helping counties. Two county supervisors cited the State's budget crisis and the effect it has had on reducing county revenues as a problem.

Table 62: Has the flexibility to decategorize mental health resources and redesign programs helped your county better meet local needs?

	Has Not Helped		Has Helped Counties Be More Responsive to Local Needs		Not Produced Desired Results Because..			
Region	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Total Number of Counties	Total Percent of Counties
Bay Area	1	11.1%	6	66.7%	2	22.2%	9	100.0%
Central	1	8.3%	8	66.7%	3	25.0%	12	100.0%
Southern	0	0.0%	8	88.9%	1	11.1%	9	100.0%
Superior	1	8.3%	9	75.0%	2	16.7%	12	100.0%
Statewide	**3**	**7.1%**	**31**	**73.8%**	**8**	**19.0%**	**42**	**100.0%**

Source: Survey of County Supervisors

Conversion of IMD Resources

Table 63 presents how local mental health departments converting IMD beds used those resources in FY 1992-93. These responses could not be analyzed according to all the unique combinations of uses that local mental health departments made of these funds. Consequently, Table 63 through Table 66 report individually the number of local mental health departments that did each action. For example, Table 63 reports 17 different uses that 14 local mental health departments made of converted IMD funds. The percentages in the last column do not add to 100 percent because they are calculated by determining what portion of the local mental health departments that responded performed each individual action.

The largest proportion of departments, 57 percent, used those funds to expand their systems of care. Twenty-one percent of the departments used the funds to cover the shortfall in the sales tax revenue; 21 percent, to cover reductions in voluntary overmatch; and 7 percent, to cover funds transferred out of mental health subaccounts. Fourteen percent used the funds to pay for rate increases for state hospital and IMD beds. The regions did make different uses of these converted IMD resources. For example, only the Bay Area and Central regions used the funds to offset reductions in sales tax revenue, and only the local mental health departments in the Bay Area used the funds to cover reductions in overmatch. In addition, all three local mental health departments in the Superior region converting IMD resources used these funds to expand their systems of care.

Table 64 illustrates how local mental health departments converting IMD resources in FY 1993-94 used those funds. No major regional differences stand out. Statewide over 70 percent of the local mental health departments used the funds to expand their systems of care. Twenty-eight percent of those departments used the funds to cover the shortfall in sales tax revenue; and 17 percent, to cover reductions in voluntary overmatch. Twenty-two percent of the local mental health departments used the funds to pay for rate increases in state hospital and IMD beds.

Six percent of the local mental health departments used the funds to offset reductions in maintenance of effort funds pursuant to Chapter 64, Statutes of 1993. This legislation, also referred to in the report as SB 627, was part of the legislative package enacting the State's budget for FY 1993-94. It provided local government with relief from a number of state mandates to partially offset the loss of local revenue in the final state budget. It affected the mental health system by allowing counties for FY 1993-94 and FY 1994-95 to reduce by up to $15 million their deposit of matching funds necessary to meet minimum federal maintenance of effort requirements.

Conversion of State Hospital Resources

Table 65 on Page 93 describes how local mental health departments used funds from converting state hospital resources in FY 1992-93. Many local mental health departments used the funds to offset revenue reductions. Forty-five percent of the departments used the funds to cover the shortfall in

sales tax revenue; 21 percent, to cover reductions in voluntary overmatch; and 10 percent, to cover transfers

Table 63: How local mental health departments converted IMD resources in FY 1992-93.

	Bay Area		Central		Sout
	Number of Responses	Percent of Counties Responding	Number of Responses	Percent of Counties Responding	Number of Responses
Funds used to cover shortfall in sales tax revenue	1	16.7%	2	50.0%	0
Funds used to cover reductions in voluntary overmatch	3	50.0%	0	0.0%	0
Funds used to cover transfers to other subaccounts	1	16.7%	0	0.0%	0
Funds used to pay for rate increases in state hospital or IMD beds	0	0.0%	1	25.0%	0
Funds used to expand systems of care	2	33.3%	2	50.0%	1
Grand Total	**7**		**5**		**1**
Number of Counties Responding	**6**		**4**		**1**

Source: Survey of Local Mental Health Departments

Table 64: How local mental health departments converted IMD resources in FY 1993-94.

	Bay Area		Central		Sout
	Number of Responses	Percent of Counties Responding	Number of Responses	Percent of Counties Responding	Number of Responses
Funds used to cover shortfall in sales tax revenue	1	16.7%	2	33.3%	0
Funds used to cover reductions in voluntary overmatch	2	33.3%	1	16.7%	0
Funds used to cover reductions in maintenance of effort from SB 627	0	0.0%	0	0.0%	0
Funds used to pay for rate increases in state hospital or IMD beds	1	16.7%	1	16.7%	0
Funds used to expand systems of care	3	50.0%	5	83.3%	1
Grand Total	**7**		**9**		**1**
Number of Counties Responding	**6**		**6**		**1**

Source: Survey of Local Mental Health Departments

Table 65: How local mental health departments used funds from converting state hospital resources in FY 1992-93.

	Bay Area		Central		S
	Number of Responses	Percent of Counties Responding	Number of Responses	Percent of Counties Responding	Number Response
To cover shortfall in sales tax revenue	3	30.0%	5	71.4%	0
To cover reductions in voluntary overmatch	5	50.0%	1	14.3%	0
To cover transfers out of mental health subaccount	2	20.0%	0	0.0%	0
To pay for rate increases in state hospital or IMD beds	4	40.0%	2	28.6%	0
To purchase IMD beds	5	50.0%	1	14.3%	2
To expand systems of care	6	60.0%	1	14.3%	2
Grand Total	**25**		**10**		**4**
Number of Counties Responding	**10**		**7**		**4**

Source: Survey of Local Mental Health Departments

Table 66: How local mental health departments used funds from converting state hospital resources in FY 1993-94.

	Bay Area		Central		S
	Number of Responses	Percent of Counties Responding	Number of Responses	Percent of Counties Responding	Number Response
To cover shortfall in sales tax revenue	3	27.3%	1	14.3%	2
To cover reductions in voluntary overmatch	5	45.5%	2	28.6%	1
To cover transfers out of mental health subaccount	2	18.2%	0	0.0%	0
To cover reductions in maintenance of effort from SB 627	1	9.1%	0	0.0%	1
To pay for rate increases in state hospital or IMD beds	2	18.2%	1	14.3%	2
To purchase IMD beds	5	45.5%	1	14.3%	0
To expand systems of care	6	54.5%	6	85.7%	3
Grand Total	**24**		**11**		**9**
Number of Counties Responding	**11**		**7**		**7**

Source: Survey of Local Mental Health Departments

out of mental health subaccounts. Additionally, in FY 1992-93 28 percent of the local mental health departments converting state hospital resources used the funds to pay for rate increases in state hospital and IMD beds. Another 38 percent used the funds to purchase additional IMD beds, and 35 percent of the local mental health departments converting these resources used the funds to expand their systems of care.

Differences exist among regions in how local mental health departments used the funds. In the Central region, 71 percent of the local mental health departments used converted state hospital funds to offset the shortfall in sales tax revenue. In the Superior region, 63 percent used the funds for this purpose. None of the local mental health departments in the Southern region did so, and only 30 percent of the departments in the Bay Area used the funds to offset the sales tax shortfall. The Bay Area also differed from the other regions in that a much higher proportion of its local mental health departments used the converted state hospital funds to cover reductions in overmatch and subaccount transfers. Another significant difference is that over half the local mental health departments in the Bay Area and Southern regions expanded their systems of care with these funds. However, only 13-14 percent of the local mental health departments in the Central and Superior regions used those funds for that purpose.

Table 66 describes how local mental health departments used the funds from converting state hospital resources in FY 1993-94. Twenty-eight percent of the local mental health departments used the funds from converting state hospital resources to cover the shortfall in sales tax revenue; 25 percent to offset reductions in voluntary overmatch; 6 percent to cover funds transferred out of mental health subaccounts; and 9 percent to cover reductions in maintenance of effort pursuant to Chapter 64, Statutes of 1993. In FY 1993-94, 25 percent of local mental health departments converting state hospital resources used the funds to pay for rate increases in state hospital and IMD beds; and 25 percent, to purchase additional IMD beds. In contrast to FY 1992-93, significantly more local mental health departments chose to use the funds to expand their systems of care. Fifty-six percent of them used the funds for this purpose in FY 1993-94 compared with 35 percent in FY 1992-93.

Several regional differences stand out for FY 1993-94. A higher proportion of local mental health departments in the Superior region used the converted state hospital funds to offset the shortfall in sales tax revenue. A higher proportion of local mental health departments in the Bay Area used the funds to offset reductions in overmatch. In addition, a much higher proportion of counties in the Central region used the funds to expand their systems of care.

Effect of Resource Flexibility on State Hospitals

Program Realignment removed direct funding for the state mental hospital system and gave these funds to the counties to contract with the state hospitals or with local providers....This new arrangement has changed the nature of the relationship between the counties and the state hospitals: the county is the customer and the state hospital is the contractor....[S]tate hospitals have shifted from a monopoly to a market orientation and, as a result, have made some significant changes....This changed relationship has brought about to the state hospital system a new, open attitude toward the provision of services.

Town Hall Meeting on Program Realignment
San Francisco, CA, May 27, 1994

Finding

Reduction in the number of state hospital beds for which counties contracted stimulated state hospital reform.

Realignment fundamentally changed the nature of state hospitals by converting a previously fixed asset, the state hospital bed allocation, into a fungible asset. The DMH became a provider from whom local mental health departments could choose to contract for long-term care services. Table 67 shows that from FY 1990-91, the year before realignment was implemented, to FY 1994-95 local mental health departments have reduced the number of state hospital beds for which they contract by over 1,000 beds, over a forty percent reduction. The draft "Strategic Plan for State Hospital Resources" prepared by the DMH and the CMHDA provides the following explanation for the reduction:

> ...the purchase by counties of state hospital beds had significantly declined causing rates of the remaining beds to escalate dramatically as hospitalwide overhead costs were spread over an increasing smaller number of beds. The bed reductions occurred as a result of several factors, including the limited array of services at the state hospitals, the high cost of services available, the limited purchasing power of counties as a result of California's weak economic situation, and the decisions of some counties to redirect funding into community-based programs to bring clients back to their home communities.

In response to this crisis, the DMH began to reform its state hospitals to be more responsive to the needs of local mental health departments and to reduce the cost of services. These efforts have produced a number of positive results. For example, all three state hospitals serving LPS patients have established partial hospitalization programs. Alternative levels of care, such as Wellspring at Napa State Hospital and the psychiatric rehabilitation program at Metropolitan State Hospital, have been established. In addition, the DMH has initiated a very successful effort to increase third-party revenues from sources such as Medicare and Medi-Cal in order to offset the rates charged to local mental health departments.

The DMH and CMHDA have also initiated a long-term reform project referred to as the "Future of State Hospitals Task Force," which includes other key stakeholders. This group has produced the draft strategic plan mentioned above. The task force is presently conducting regional meetings to identify the service needs in each region and to propose plans to meet those needs with particular attention to the role of state hospitals in enhancing the community-based service system.

Finding

The DMH may need to take additional steps to meet the needs of small counties for access to state hospitals.

Implementing the provisions of realignment that required local mental health departments to contract for state hospital beds presented a challenge for small counties. The DMH and CMHDA had to develop an affordable mechanism for small counties to contract for portions of beds that also provided access to the various types of beds. As a result, the DMH established the Small County Bed Pool. Table 67 presents the number of beds in the pool since it was established in FY 1992-93. The first year 21 local mental health departments joined the pool and contracted for 49 beds. The second year 17 departments contracted for 19 beds. During FY 1994-95, the number of counties participating dropped to 14 with the number of beds declining slightly to 16.5.

The main reason for the decline is that small counties cannot afford to spend money on state hospital beds. For very small counties, even half of a state hospital bed, which would cost approximately $50,000 annually, is beyond their means. Instead, they are using the funds to develop their community-based service systems and hoping that they do not need to place a client in a state hospital. In three of the small counties responding to the surveys, county supervisors and local mental health directors expressed concern that the need to hospitalize just one client could bankrupt their mental health budgets. The concern among county officials and the significant decline in the participation in the Small County Bed Pool indicates that additional solutions need to be found to provide small counties with access to long-term care resources.

Table 67: State hospital bed allocation, contracts, and requests for FY 1990-91 to FY 1994-95.

Counties	FY 1990-91 Allocation	FY 1991-92 Allocation	FY 1992-93 Contract	FY 1993-94 Contract	FY 1994-95 Request
Alameda	165	93	89	76	76
Alpine *	0	1	(.8)	(.5)	0
Amador *	0	2	(.5)	(.25)	0
Butte	0	7	2	0	0
Calaveras *	1	1	(1)	(0)	0
Colusa	2	2	1	1	0
Contra Costa	94	85	71	39	37
Del Norte *	1	1	(1)	(.5)	(.25)
El Dorado	2	2	(2)	1	1
Fresno	15	15	22.3	22	15
Glenn	1	1	0	0	0
Humboldt	8	8	(2)	2	2
Imperial	0	3	3	3	3
Inyo *	4	4	(1)	(.5)	(0.5)
Kern	42	42	34	14	5
Kings	3	3	2	1	1
Lake	3	3	(3)	(1)	(0)
Lassen *	0	2	(2)	(.25)	(.25)
Los Angeles	1,080	1,080	844	759	759
Madera	1	1	3	3	(1)
Marin	34	30	15	12	9
Mariposa	0	1	0	0	0
Mendocino	5	5	(5)	4	3
Merced	4	4	2	2	1
Modoc *	1	1	(1)	(.5)	0
Mono *	1	1	(1)	(1)	(.5)
Monterey	22	22	17	10	9
Napa	25	25	16	14	13
Nevada *	5	5	(5)	(3)	(2)
Orange	148	148	148	142	97
Placer	9	9	(8)	5	5.0
Plumas *	0	1	(1)	(.25)	(.25)
Riverside	52	52	52	48	48
Sacramento	48	48	48	32	32
San Benito *	3	3	(1)	(.5)	(.25)
San Bernardino	59	59	56	38	36
San Diego	71	71	91	71	38
San Francisco	249	214	117	97	87
San Joaquin	10	10	9	5	5
San Luis Obispo	8	8	7	7	6
San Mateo	68	68	55	51	42
Santa Barbara	23	23	18	19	19
Santa Clara	75	75	75	58	58
Santa Cruz	15	15	10	7	4
Shasta *	12	12	(7)	(6)	(6)
Sierra *	0	1	0	(0)	(0)
Siskiyou	1	1	(1.2)	0	
Solano	56	44	38	36	32
Sonoma	28	26	18	16	12
Stanislaus	18	18	15	14	12
Sutter/Yuba	4	4	4	4	4
Tehama *	4	4	(2)	(2)	(2)
Trinity *	1	1	(.5)	(.5)	(.5)

Recommendation

The DMH and the CMHDA should collaborate to examine the risk to small counties from not participating in the Small County Bed Pool. In addition, they should explore options for providing small counties with affordable methods of accessing long-term care services, such as developing a Fee-for-Service method enabling small counties to contract for very limited usage of state hospital beds and exploring the feasibility of regional long-term care services.

Use of Resource Flexibility To Expand Systems of Care

Finding

Local mental health departments used the resource flexibility provided by realignment to augment their community-based systems of care.

One of the goals of realignment was to increase the flexibility of resources provided to local mental health departments by converting state hospital and IMD bed allocations to funds so that local mental health departments could use all their resources to better meet local needs. Although realignment was designed to give local mental health departments greater autonomy in designing their systems of care, the *Master Plan*, through its chapters describing the ideal systems of care for each target population, aimed to provide guidance in the development of those systems of care. These service models were enacted in statute in WIC Sections 5000.4 through 5000.7. However, these sections are permissive, establishing the requirements only "to the extent resources are available."

To date, no review has been conducted of how systems of care for each target population in local mental health programs compare with the minimum array of services described in statute. The following sections report on how local mental health departments expanded their systems of care by converting institutional resources. However, these sections do not evaluate whether local mental health departments are redesigning their systems of care in ways envisioned by the *Master Plan.*

Adult System of Care

Table 68 presents how local mental health departments used state hospital and IMD resources to expand their systems of care for adults during FY 1992-93 and FY 1993-94. The largest number of services were clustered in the areas of housing, case management, and intensive treatment teams. In the area of housing and residential treatment, 36 percent of the local mental health departments expanding their adult systems of care added residential treatment programs; 24 percent added more beds in board and care homes or augmented the rates of board and care homes so they would accept clients needing higher levels of support; and 20 percent increased the number of board and care homes receiving payments at the level of the Supplemental Rate Program.

Within the cluster of housing and residential treatment services, regions emphasized different modalities. The Bay Area and the Superior regions emphasized residential treatment programs with 50 and 43 percent of the local mental health departments in those regions, respectively, adding residential treatment. The Central and Southern regions emphasized adding board and care beds with 43 and 67 percent of those local mental health departments, respectively, adding that modality.

In the case management and treatment team cluster, 24 percent of the local mental health departments expanding their adult systems of care added case management services. Twenty percent added intensive case management services or intensive treatment teams with staff available 24 hours per day, 7 days per week. Twelve percent of the local mental health departments used their state hospital and IMD resources to establish integrated service agencies. Regionally, differences emerge. Only two regions in the State actually expanded their case management services: 25 percent of the

local mental health departments in the Bay Area and 57 percent of them in the Superior region. Adding intensive

Table 68: How local mental health departments expanded their systems of care by converting state hospital or IMD r

	Bay Area		Central		Sout
Services Added to Systems of Care	Number of Responses	Percent of Counties Responding	Number of Responses	Percent of Counties Responding	Number of Responses
Adult System of Care					
Acute Services/Crisis Response	3	37.5%	0	0.0%	1
Residential Treatment Programs	4	50.0%	1	14.3%	1
Board and Care/Augmented Board and Care	0	0.0%	3	42.9%	2
Supplemental Rate Program	1	12.5%	2	28.6%	1
Supported Housing	2	25.0%	1	14.3%	0
Outpatient Medication Clinic	1	12.5%	0	0.0%	0
Day Treatment/Intensive Day Treatment	0	0.0%	0	0.0%	0
Case Management Services	2	25.0%	0	0.0%	0
Intensive Case Management/Treatment Teams	4	50.0%	0	0.0%	1
Integrated Service Agencies	0	0.0%	2	28.6%	1
Clubhouse/Peer Support	1	12.5%	0	0.0%	1
Medical Services	1	12.5%	0	0.0%	2
Dual Diagnoses Services	2	25.0%	1	14.3%	0
Forensic Services--Adults	1	12.5%	0	0.0%	1
Com. M. H. Services for Adults--Unspecified	0	0.0%	1	14.3%	1
Total	22		11		12
# of Co.'s Expanding Adult SOC	**8**		**7**		**3**
Children's System of Care					
Acute Inpatient Services	1	25.0%	0	0.0%	0
Residential Care	3	75.0%	2	100.0%	1
Youth Transitional Residential Program	1	25.0%	0	0.0%	0
Child Outpatient Services	0	0.0%	1	50.0%	0
Mental Health Services at Schools	2	50.0%	0	0.0%	0
In-home Services/Wraparound Services	1	25.0%	0	0.0%	0
Case Management Services	2	50.0%	0	0.0%	0
Medical Services	0	0.0%	0	0.0%	1
Youth Prevention Services	0	0.0%	0	0.0%	1
Children's Services--Unspecified	1	25.0%	0	0.0%	0
Total	11		3		3
# of Co.'s Expanding Children's SOC	**4**		**2**		**2**

Table 68: continued

	Bay Area		Central		Sout
Services Added to Systems of Care	Number of Responses	Percent of Counties Responding	Number of Responses	Percent of Counties Responding	Number of Responses
Older Adult Services					
Residential Program	6	100.0%	0	0	0
Case Management	1	16.7%	0	0	0
Total	7		0		0
# of Co.'s Expanding Older Adult SOC	**6**		**0**		**0**

Source: Survey of Local Mental Health Departments

case management and treatment teams occurred only in the Bay Area and Southern region. Integrated service agencies were developed by 2 local mental health departments in the Central region and one in the Southern region.

Observing what local mental health departments chose not to do with their funds is also interesting. Despite all the discussion in recent years about the serious need to expand services for mental health clients who have a chemical dependency, only three local mental health departments, 12 percent, added services for clients with dual diagnoses. The mental health constituency is also becoming quite concerned about the increasing rate at which persons with serious mental illnesses are incarcerated. Yet, only 2 local mental health departments, 8 percent, added forensic mental health programs.

Children's System of Care

In expanding their children's systems of care, local mental health departments focused on residential care, mental health services provided in schools, and case management. Sixty-seven percent of the local mental health departments expanding their children's systems of care added residential care services for children. More than half of the departments in each region except the Superior region added residential care beds. Thirty-three percent of the departments expanding their children's systems of care added mental health services provided at school sites with 50 percent of the departments in the Bay Area and all the departments in the Superior region doing so. Local mental health departments in the Central and Southern regions did not add this type of service. All the case management services for children were added in the Bay Area with 50 percent of those departments adding that service component.

Older Adult System of Care

Only six local mental health departments, all of whom are in the Bay Area, used their state hospital and IMD resources to expand their systems of care for older adults. These departments pooled their resources and developed a residential program that is an alternative to hospitalization at Napa State Hospital. In addition, one of the local mental health departments also developed case management services for older adults.

Recommendation

- The CMHPC should develop a means for determining whether local mental health departments are redesigning their systems of care consistent with principles and guidelines contained in the Master Plan and statutory provisions on minimum arrays of services for each target population.
- In its revision of the *Master Plan*, the CMHPC should strive to discover ways of encouraging state and local budget and policy decisions that develop programs responding to unmet needs in the mental health system, such as services for clients with dual diagnoses and for clients who become incarcerated.

Finding

In expanding their systems of care, local mental health departments focused primarily on their systems of care for adults.

Table 69 on Page 103 shows the number of local mental health departments converting state hospital or IMD resources in FY 1992-93 and FY 1993-94. Statewide 93 percent of the departments converting resources invested those funds in systems of care for adults. Thirty-three percent invested resources in children's systems of care, and 22 percent invested in older adult systems of care.

On a regional basis, patterns for the systems of care for children and older adults differ from the statewide figures. Fifty percent of the local mental health departments in the Bay Area and 67

percent of them in the Southern region invested their resources in the children's systems of care. Those

Table 69: Systems of care expanded by local mental health departments converting state hospital and IMD resources

	Bay Area		Central		Sout
System of Care Expanded	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Number of Counties
Adult SOC	8	100.0%	7	77.8%	3
Children's SOC	4	50.0%	2	22.2%	2
Older Adult SOC	6	75.0%	0	0.0%	0
Total # of Co.'s Expanding SOC	**8**		**9**		**3**

Source: Survey of Local Mental Health Departments

figures are much higher than the 33 percent statewide. For the older adult systems of care, 75 percent of the local mental health departments in the Bay Area developed new programs, which is much higher than the 22 percent figure statewide.

One major reason for the higher investment in the systems of care for adults is that adults were in the state hospital and IMD beds that local mental health departments converted into funds. Services needed to be developed for these clients in the community. The emphasis on services that provide housing substantiates that assumption. In addition, once clients were living in the community, local mental health departments needed to offer the necessary supportive services, such as case management, to provide clients with a successful new placement.

Systems of care for children and older adults, which need significant expansion in the type and quantity of mental health services available, received fewer benefits from the conversion of state hospital and IMD beds. More local mental health departments expanded their children's systems of care than their older adult systems of care. Several factors account for this difference. The mental health system has developed a model children's system of care whose effectiveness has been thoroughly proven through pilot testing. The State has been able to expand funding to increase the number of counties that implement this system of care through federal grants and Chapter 1229, Statutes of 1992 (AB 3015--Wright), in part because the cost-effectiveness of this system of care has been established. However, the mental health system has not paid the same amount of attention to older adults. No similar model system of care has been developed or tested to determine whether it is cost-effective.

Recommendation

The mental health system needs to focus on expanding the systems of care for children and older adults by taking the following steps:

- continue to find additional funding for increasing the number of counties able to implement the children's system of care;
- develop a model system of care for older adults; and
- enact legislation with adequate funding to conduct a pilot test of the effectiveness of the model system of care for older adults.

Providing Culturally Competent Services

Finding

Further study is needed to determine whether local mental health programs are making efforts to increase the cultural competency of services.

WIC Section 5600.2 states, "To the extent resources are available, public mental health services in this state should be provided to priority target populations in systems of care that are...culturally competent." WIC Section 5600.2(g) defines cultural competence as follows:

> All services and programs at all levels should have the capacity to provide services sensitive to the target populations' cultural diversity. Systems of care should:
>
> 1. Acknowledge and incorporate the importance of culture, the assessment of cross-cultural relations, vigilance towards dynamics resulting from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs.

2. Recognize that a culture implies an integrated pattern of human behavior, including language, thoughts, beliefs, communications, actions, customs, values, and other institutions of racial, ethnic, religious, or social groups.
3. Promote congruent behaviors, attitudes, and policies enabling the system, agencies, and mental health professionals to function effectively in cross-cultural institutions and communities.

To meet the requirements in statute, local mental health programs should be able to respond to the needs of the ethnic groups in their communities. Table 71 summarizes the distribution of ethnicity in California by region. Of all the regions, the counties in the Bay Area and the Southern regions have the greatest ethnic diversity. In the Bay Area, 17 percent of their counties' population is Latino; 14 percent, Asian; and 8 percent, African American. In the Southern region, 31 percent of their population is Latino; 9 percent, Asian; and 7 percent, African American. In the Central region, the proportion of African Americans, 5 percent, is below the statewide average of 7 percent. However, counties in the Central region have a significant amount of Latinos, 22 percent, and Asians, 8 percent. The counties in the Superior region have less ethnic diversity than other counties in the State. The proportions of all ethnic minority groups in the Superior region are below the statewide averages. However, the proportion of whites, 87 percent, exceeds the statewide average of 57 percent.

This study attempted to determine what activities local mental health departments have initiated since FY 1990-91 to increase the cultural competency of their services. However, responses to the surveys concerning new programs initiated, the number of staff hired or trained, and the number of clients served was too incomplete to analyze. In addition, an assessment of the needs of ethnic minorities for mental health services has not been conducted.

Recommendation

The California Mental Health Planning Council should work with the DMH and other stakeholders to plan an assessment of the needs of ethnic minorities for mental health services. This study should also determine the extent to which local mental health programs are meeting those needs and develop an action plan for reducing unmet need.

Conclusion

In the late 1980's and early 1990's, the process of developing the *California Mental Health Master Plan* was a crucible for reaching consensus about key aspects of system reform that were implemented in legislation enacting realignment. Now, in the mid-1990's, those principles have stood the test of time and are being used in the mental health system. For example, most local mental health departments have used the *Master Plan* when planning their systems of care. However, some local mental health departments chose not to use the *Master Plan*, and most MHB/Cs are unaware of it. No doubt, the lack of awareness by MHB/Cs results from most of their members being appointed in the past two years, well after the *Master Plan* was published. The CMHPC, which will be updating the *Master Plan* in 1995, should contact local mental health departments and MHB/Cs to determine how the Master Plan should be revised so it meets their needs.

One of the basic principles of the *Master Plan* was the need to develop a more client-driven system. This study found signs that the client-driven approach is beginning to be integrated into the mental health system. For example, local mental health departments have begun to involve direct consumers and family members in planning local programs. In addition, the number of direct consumers employed in local mental health programs has increased since the implementation of realignment.

However, the mental health constituency needs to do more to encourage the mental health system to embrace fully the client-driven philosophy. Needed steps include more regional empowerment workshops and training and leadership development for direct consumers and family members. To

Table 71: California's population by region and ethnic group from the 1990 census.

Region	Total Population	Number of Whites	Percent White	Number of African Americans	Percent African Americans	Nun La
Bay Area	6,678,100	4,063,200	60.8%	544,700	8.2%	1,
Central	3,980,700	2,582,600	64.9%	192,800	4.8%	
Southern	18,400,900	9,755,200	53.0%	1,368,900	7.4%	5,
Superior	916,300	797,900	87.1%	10,000	1.1%	
Statewide	**29,976,000**	**17,198,900**	**57.4%**	**2,116,400**	**7.1%**	**7,**

Source: Report 93 P-1: Populations by Race/Ethnicity for California and its Counties 1990-2040, Der

[11] These data are from the Department of Finance reported ethnicity by county for Whites, African Americans, Latinos, and Othe compatible with the number of "Other" reported initially, revealed that 88.6 percent of this category were Asians. Asians in Hmong, Laotian, Thai, and Other Asians. Another 3.6 percent were Pacific Islanders. The remaining 7.8 percent were sufficiently compatible, the number of Native Americans by county could not be separately report and used in the analysis. Islanders, this category is labeled as "Asian."

increase the employment of direct consumers, key stakeholders must develop an action plan that identifies barriers to increasing employment and provides solutions.

One of the accomplishments of the *Master Plan* was developing definitions for priority target populations, including children and youth, adults, and older adults. These definitions were enacted in the realignment legislation. However, the study found that the trend to shift services to priority target populations began before the implementation of realignment. From FY 1986-87 to FY 1992-93, the proportion of total clients served who met the definitions for target populations increased by 9.8 percent. However, most of that increase, 7.6 percent, occurred between FY 1986-87 and FY 1990-91, the period preceding implementation of realignment. The remaining 2.2 percent of that increase occurred after realignment was implemented.

Another central tenet of the *Master Plan* was providing mental health services in integrated systems of care. One of the most revolutionizing elements of realignment, converting state hospital and IMD bed allocations into fungible assets, stimulated the expansion of community-based systems of care. Local mental health departments to a very significant degree took advantage of this aspect of realignment by converting IMD and state hospital beds to funds. Although the hope was that these funds would be invested in systems of care, due to the shortfall in realignment revenues the first year of implementation, the preponderance of counties used these funds to offset a variety of revenue losses. However, in FY 1993-94 they began to use the funds to a greater extent to expand their systems of care.

This conversion of state hospital resources stimulated significant reform efforts in state hospitals. As a result of reducing the number of state hospital beds, rates began to rise because the hospitals' fixed costs had to be spread over fewer and fewer beds. The DMH developed lower cost programs that better met the needs of counties, and it significantly increased third-party revenues to reduce the portion of the costs that had to be charged to counties. In addition, the DMH, CMHDA, and other stakeholders have established a task force that is developing a strategic plan for long-term reform.

This study has revealed, however, that more needs to be done to meet the needs of small counties for access to long-term care resources. Revenue shortfalls have caused many small counties to drop out of the Small County State Hospital Bed Pool, leaving them at significant financial risk if even one of their clients requires placement in a state hospital.

In examining how local mental health departments used funds from converting state hospital and IMD resources, this study was not able to obtain sufficiently complete information concerning the quantity of services added or the actual dollar amounts invested. However, information is available concerning the types of services added and the number of counties that did so. Because most of the converted institutional beds had been occupied by adults, most of the services added in the community were for adults. Most of those services were for housing and residential treatment, case management, and intensive treatment teams.

No assessment has been completed of whether local mental health departments are developing their service systems consistent with the statutory guidelines and the principles contained in the *Master Plan*. In addition, this study found that emerging needs for programs serving clients with dual diagnoses and for clients who are incarcerated are not being developed to a significant degree. Consequently, the CMHPC should develop a means for determining whether local mental health departments are developing their systems of care in keeping with the *Master Plan*. The CMHPC should also determine how to stimulate the development of services for emerging unmet needs.

This study also focuses attention on the lack of priority being placed on the needs of older adults. The adult system of care continues to be expanded. The children's system of care, propelled by AB 377 and AB 3015, is expanding. However, the mental health system has not developed or tested a model system of care for older adults. The CMHPC should advocate for the development of such a model and for legislation to fund a pilot test.

The *Master Plan* also emphasized providing culturally competent services to mental health clients. Although the study was able to provide a profile of the ethnic groups in each region, it was not able to

report on efforts to expand culturally competent services due to incomplete responses to the survey. Moreover, the mental health system has not conducted an assessment of the unmet need among ethnic minority groups for culturally competent services. The CMHPC should advocate for such a study as a necessary first step in improving the availability of culturally competent services.

CHAPTER 6

OVERALL EFFECTS OF REALIGNMENT

Overall Ratings

Finding

Local mental health departments, governing bodies, and MHB/Cs rate the overall effects of realignment as "somewhat positive."

Local mental health departments, governing bodies, and MHB/Cs were asked to rate the overall effects of realignment on a scale of 1 to 5 with 1 being "very positive" and 5 being "very negative." Table 72 shows the average of ratings for each group. The statewide average rating by local mental health departments was 1.95, slightly higher than the score for "somewhat positive." For the MHB/Cs, it was 2.14; and for the county supervisors, it was 2.12. Both scores are slightly lower than "somewhat positive."

Table 72: Average of the ratings of the overall effects of realignment.

	Average		
Region	Mental Health Departments	MHB/Cs	County Supervisors
Bay Area	1.50	2.45	1.89
Central	1.94	2.14	2.33
Southern	2.00	1.89	1.78
Superior	2.27	2.00	2.33
Statewide	**1.95**	**2.14**	**2.12**

Source: Survey of Local Mental Health Departments, Mental Health Boards/Commissions, and County Supervisors

Local mental health departments may have rated the overall effects of realignment more generously because of the immediate advantages it afforded them, such as guaranteed funding and the flexibility to use funding previously dedicated to the purchase of state hospital and IMD beds for more versatile purposes. MHB/Cs, on the other hand, may have expected realignment to change the complexion of the mental health system more dramatically by emphasizing a client-driven philosophy and by providing more opportunity for MHB/Cs to influence the mental health system. Although the intent of realignment was to accomplish both of these goals, the benefit has accrued more immediately to local mental health departments.

The governing bodies' slightly lower ranking of the effects of realignment may result from the county fiscal crisis, which was triggered by the state budget crisis the past few years. The data in Table 73 on Page 110 substantiate this conclusion. This table breaks down the county supervisors' ratings of realignment according to whether they believe realignment stabilized funding. The average rating for county supervisors who believe that realignment stabilized funding is 1.64, approaching the score for "very positive." In contrast, county supervisors who do not believe that realignment stabilized funding rated the effect at 2.72, very close to "neutral."

Table 73: Average ratings of the overall effects of realignment reported by whether or not county supervisors believe that realignment stabilized funding.

Realignment Stabilized Funding	Region	Average
Yes	Bay Area	1.25
	Central	2.00
	Southern	1.50
	Superior	1.50
Subtotal		**1.64**
No	Bay Area	2.40
	Central	3.00
	Southern	2.33
	Superior	3.00
Subtotal		**2.72**
Statewide		**2.12**

Source: Survey of County Supervisors

Positive and Negative Effects

Finding

Local mental health departments and the MHB/Cs were fairly close in their assessments of the positive and negative effects of realignment.

Table 75 on Page 112 and Table 77 on Page 113 show that both local mental health departments and the MHB/Cs perceived the same positive effects of realignment:

- The sales tax is a stable source of funding with potential for growth (local mental health departments: 79 percent; MHB/Cs: 53 percent);
- Resource flexibility with state hospital and IMD beds lets local mental health departments develop more community-based services (local mental health departments: 77 percent; MHB/Cs: 67 percent);
- A stable funding source produces more effective local budgeting and planning (local mental health departments: 48 percent; MHB/Cs: 42 percent);
- The client-centered philosophy in statute led to positive changes (local mental health departments: 46 percent; MHB/Cs: 60 percent); and
- Realignment enabled local mental health programs to do more local planning (local mental health departments: 46 percent; MHB/Cs: 53 percent).

Table 79 on Page 114 and Table 81 on Page 115 show that both local mental health departments and the MHB/Cs share the following concerns about the negative effects of realignment:

- Sales tax, which is dependent on the economy, is not a stable source of revenue (local mental health departments: 88 percent; MHB/Cs: 85 percent);
- The sales tax shortfall reduced resources (local mental health departments: 77 percent; MHB/Cs: 80 percent);

- Narrowly defined target population definitions deny services to others in need (local mental health departments: 51 percent; MHB/Cs: 85 percent);
- Reduction in state hospital beds increased rates (local mental health departments: 47 percent: MHB/Cs: 46 percent); and
- Dedicated funding encourages counties to redefine general fund expenditures as mental health expenditures (local mental health departments: 37 percent; MHB/Cs: 41 percent).[12]

Conclusion

Local mental health departments, governing bodies, and MHB/Cs all rate realignment as "somewhat positive." Paradoxically, the most frequently identified positive effects of realignment are all contradicted by the most frequently identified negative effects. This situation reflects the complexities of realignment and the economic and political environment in which the mental health system operates. Consequently, people have beliefs about realignment and its effects that on the surface appear inconsistent. For example, mental health directors and MHB/C members identified as one of the most positive effects that realignment switched the revenue source for mental health to the sales tax, which they believe is a stable source of funding with potential for growth. At the same time, these respondents identified the most negative effect of realignment to be the sales tax shortfall resulting from the economic recession that California has been experiencing.

These contradictory beliefs can be reconciled by understanding that some of them result from taking the long view of the potential benefits of realignment and some result from evaluating the short-term consequences. In the long run, the mental health system is probably better off with a dedicated funding source that insulates it from competition with entitlement programs in the General Fund. In the short run, enacting realignment, which used a revenue source sensitive to the health of the economy, just as a recession was hitting California had very negative consequences for mental health programs that had to reduce the services they provided.

[12] Many local mental health departments and MHB/Cs believe that because local mental health programs now have a dedicated funding source, many county governments are including as mental health programs county services that previously were not funded from mental health funds.

Table 75: Frequency distribution of the positive effects of realignment identified by local mental health departments.

	Bay Area		Central		Sout
	Number of Responses	Percent of Counties Responding	Number of Responses	Percent of Counties Responding	Number of Responses
Sales tax is a stable source of funding with potential for growth	10	83.3%	13	76.5%	8
Resource flexibility with state hospital and IMD beds lets counties develop more community-based services	11	91.7%	14	82.4%	8
A stable funding source produces more effective local budgeting and planning	4	33.3%	9	52.9%	6
Statute provides a clearer focus on priorities and service system components	6	50.0%	7	41.2%	6
Client-centered philosophy in statute led to positive changes	8	66.7%	7	41.2%	4
Realignment enabled counties to do more local planning	6	50.0%	8	47.1%	5
Realignment stimulated the development of a more competitive, cost-effective service delivery system	7	58.3%	4	23.5%	7
Accountability of local government increased	0	0.0%	5	29.4%	5
Realignment stimulated regional cooperation	2	16.7%	8	47.1%	1
Performance outcome measures have led to positive changes	2	16.7%	2	11.8%	3
Changing composition and appointment process of MHB/Cs produced more interaction with governing bodies	1	8.3%	3	17.6%	1
Grand Total	**57**		**80**		**54**
Number of Counties Responding	**12**		**17**		**11**

Source: Survey of Local Mental Health Departments

Table 77: Frequency distribution of positive effects of realignment identified by MHB/Cs.

	Bay Area		Central		Sout
	Number of Responses	Percent of Counties Responding	Number of Responses	Percent of Counties Responding	Number of Responses
Resource flexibility with state hospital and IMD beds lets counties develop more community-based services	9	81.8%	8	66.7%	8
Client-centered philosophy in statute led to positive changes	7	63.6%	7	58.3%	8
Sales tax is a stable source of funding with potential for growth	5	45.5%	5	41.7%	7
Realignment enabled counties to do more local planning	7	63.6%	4	33.3%	7
A stable funding source produces more effective local budgeting and planning	4	36.4%	4	33.3%	5
Accountability of local government increased	4	36.4%	5	41.7%	3
Realignment stimulated a more competitive, cost-effective service delivery system	3	27.3%	4	33.3%	3
Statute provides a clearer focus on priorities and service system components	5	45.5%	4	33.3%	4
Performance outcome measures have led to positive changes	3	27.3%	4	33.3%	4
Realignment stimulated regional cooperation	4	36.4%	4	33.3%	1
Changing composition and appointment process of MHB/Cs produced more interaction with governing body	2	18.2%	3	25.0%	4
Grand Total	**53**		**52**		**54**
Number of Counties Responding	**11**		**12**		**10**

Source: Survey of Mental Health Boards/Commissions

Table 79: Frequency distribution of negative effects of realignment identified by local mental health departments.

	Bay Area		Central		S
	Number of Responses	Percent of Counties Responding	Number of Responses	Percent of Counties Responding	Number Respons
Sales tax, which is dependent on the economy, is not a stable source of revenue	9	75.0%	15	83.3%	10
Sales tax shortfall reduced resources	11	91.7%	11	61.1%	8
Narrowly defined target population definitions deny services to others in need	5	41.7%	10	55.6%	5
Reduction in state hospital beds increased rates	5	41.7%	8	44.4%	6
Technical assistance is limited because few understand realignment	4	33.3%	9	50.0%	6
Dedicated funding encourages co.'s to redefine gen. fund exp.'s as mental health exp.'s	6	50.0%	8	44.4%	3
Statewideness of mental health services has diminished	3	25.0%	5	27.8%	4
Mental health funding is vulnerable due to the subaccount transfer provision	1	8.3%	3	16.7%	2
The DMH's role is not clearly defined	2	16.7%	1	5.6%	0
Realignment is subject to legislative change, which could be disadvantageous	0	0.0%	1	5.6%	1
Mental health funding is inadequate	0	0.0%	0	0.0%	1
State budget crisis is reducing other sources of revenue for counties	2	16.7%	0	0.0%	1
Inequities in funding have not been addressed	1	8.3%	1	5.6%	0
Grand Total	**49**		**73**		**47**
Number of Counties Responding	**12**		**18**		**11**

Source: Survey of Local Mental Health Departments

Table 81: Frequency distribution of negative effects of realignment identified by MHB/Cs.

	Bay Area		Central		S
	Number of Responses	Percent of Counties Responding	Number of Responses	Percent of Counties Responding	Number Respons
Sales tax, which is dependent on the economy, is not a stable source of revenue	11	91.7%	8	66.7%	9
Narrowly defined target population definitions deny services to others in need	11	91.7%	10	83.3%	8
Sales tax shortfall reduced resources	12	100.0%	9	75.0%	10
Reduction in state hospital beds increased rates	4	33.3%	4	33.3%	6
Dedicated funding encourages co.'s to redefine gen. fund exp.'s as mental health exp.'s	8	66.7%	6	50.0%	2
Statewideness of mental health services has diminished	3	25.0%	5	41.7%	5
Technical assistance is limited because few understand realignment	2	16.7%	7	58.3%	3
Counties have the ability to transfer between subaccounts	0	0.0%	0	0.0%	2
Counties must use realignment funds to pay for underfunded state mandates	1	8.3%	0	0.0%	0
Inequities in funding have not been addressed	0	0.0%	0	0.0%	3
Budget considerations, rather than human needs, drive the system	1	8.3%	0	0.0%	1
Realignment is threatened by the continuing state budget crisis	1	8.3%	1	8.3%	0
No state-mandated organization for MHB/C's	0	0.0%	0	0.0%	1
Grand Total	**54**		**50**		**51**
Number of Counties Responding	**12**		**12**		**10**

Source: Survey of Mental Health Boards/Commissions

APPENDIX 1

REGIONAL BREAKDOWN OF COUNTIES

BAY AREA

Alameda
Berkeley City
Contra Costa
Marin
Monterey
Napa
San Benito
San Francisco
San Mateo
Santa Clara
Santa Cruz
Solano
Sonoma

SOUTHERN

Kern
Imperial
Los Angeles
Orange
Riverside
San Bernardino
San Diego
San Luis Obispo
Santa Barbara
Tri-City
Ventura

CENTRAL

Alpine
Amador
Calaveras
El Dorado
Fresno
Kings
Madera
Mariposa
Merced
Mono
Placer
Sacramento
San Joaquin
Stanislaus
Sutter-Yuba
Tulare
Tuolumne
Yolo

SUPERIOR

Butte
Colusa
Del Norte
Glenn
Humboldt
Inyo
Modoc
Lake
Lassen
Mendocino
Nevada
Plumas
Shasta
Sierra
Siskiyou
Tehama
Trinity

APPENDIX 2

FUNDING FOR THE MENTAL HEALTH SYSTEM

Table 83: Mental health revenues FY 1985-86 through FY 1989-90 (in thousands).

	FY 1985-86	FY 1986-87	% Change from FY 1985-86 to FY 1986-87	FY 1987-88	% Chan FY 1986- 198
State Revenue					
Community Programs					
General Fund	$459,000	$482,281	5.1%	$552,736	
Miscellaneous Categorical Funds[13]	$0	$0		$704	
Federal Revenue[14]	$15,357	$19,271	25.5%	$17,026	
Short-Doyle/Medi-Cal Reimbursements	$65,042	$79,325	22.0%	$94,325	
Miscellaneous Reimbursements[15]	$590	$3,645	517.8%	$8,341	
Local Revenues (Sales Tax/VLF)					
VLF Collection Account					
Subtotal	**$539,989**	**$584,522**	**8.2%**	**$673,132**	
State Hospitals					
General Fund	$265,369	$292,085	10.1%	$299,842	
Special Account for Capital Outlay	$695	$1,712	146.3%	$714	
Realignment Reimbursements					
Reimbursements from CDC and CYA[16]	$21,035	$23,515	11.8%	$23,861	
Miscellaneous Reimbursements[17]	$2,807	$8,094	188.4%	$3,657	
Subtotal	**$289,906**	**$325,406**	**12.2%**	**$328,074**	
Total	**$829,895**	**$909,928**	**9.6%**	**$1,001,206**	
County Revenues					
Overmatch[18]	$24,210	$32,165	32.9%	$42,301	
Net Subaccount Transfers					
Total	**$24,210**	**$32,165**	**32.9%**	**$42,301**	
Grand Total	**$854,105**	**$942,093**	**10.3%**	**$1,043,507**	

Source: Department of Mental Health, Governor's Budgets, CMHDA, and State Controller

[13] Miscellaneous Categorical Funds include the following funds: Asset Forfeiture Distribution Fund; Cigarette and To Tobacco Tax (Unallocated Account); Traumatic Brain Injury Fund; and Mental Health Primary Prevention Fund.
[14] Federal Revenues include the following funds: SLIAG; Federal Block Grant; and Miscellaneous Federal Funds
[15] Miscellaneous Reimbursements include $88 million in IMD beds the State carried for FY 1991-92.
[16] Reimbursements from the California Department of Corrections and the California Youth Authority.
[17] Miscellaneous Reimbursements include patient-generated reimbursements.
[18] From FY 1985-86 through FY 1989-90, the DMH provided data. From FY 1990-91 to FY 1993-94, the CMHDA p

Table 84: Mental health revenues FY 1990-91 through FY 1994-95 (in thousands).

	FY 1990-91	% Change from FY 1989-90 to FY 1990-91	FY 1991-92	% Change from FY 1990-91 to FY 1991-92	FY 1992-93
State Revenue					
Community Programs					
General Fund	$544,469	-8.3%	$38,029	-93.0%	$39,348
Miscellaneous Categorical Funds[19]	$42,197	57.7%	$42,193	0.0%	$500
Federal Revenue[20]	$31,944	-0.6%	$23,510	-26.4%	$36,980
S/D-M/C Reimbursements	$111,025	1.6%	$166,000	49.5%	$185,000
Miscellaneous Reimbursements[21]	$13,326	-6.1%	$100,044	650.7%	$4,477
Local Revenues (Sales Tax/VLF)			$429,517		$491,199
VLF Collection Account					$14,000
Subtotal	**$742,961**	**-4.3%**	**$799,293**	**7.6%**	**$771,504**
State Hospitals					
General Fund	$368,932	9.1%	$150,576	-59.2%	$139,442
Special Account for Capital Outlay		-100.0%	$2,435		$139
Realignment Reimbursements			$238,492		$217,788
Reimbursements from CDC and CYA[22]	$41,721	3.7%	$41,076	-1.5%	$38,990
Miscellaneous Reimbursements[23]	$2,648	-19.8%	$2,643	-0.2%	$2,613
Subtotal	**$413,301**	**7.8%**	**$435,222**	**5.3%**	**$398,972**
Total	**$1,156,262**	**-0.3%**	**$1,234,515**	**6.8%**	**$1,170,476**
County Revenue					
Overmatch[24]	$144,195	145.7%	$151,774	5.3%	$147,117
Net Subaccount Transfers			$4,659		$2,480
Total	**$144,195**	**145.7%**	**$156,433**	**8.5%**	**$149,597**
Grand Total	**$1,300,457**	**6.8%**	**$1,390,948**	**7.0%**	**$1,320,073**

Source: Department of Mental Health, Governor's Budgets, CMHDA, and State Controller

[19] Miscellaneous Categorical Funds include the following funds: Asset Forfeiture Distribution Fund; Cigarette and Tobacco (Unallocated Account); Traumatic Brain Injury Fund; and Mental Health Primary Prevention Fund.

[20] Federal Revenues include the following funds: SLIAG; Federal Block Grant; and Miscellaneous Federal Funds

[21] Miscellaneous Reimbursements include $88 million in IMD beds the State carried for FY 1991-92.

[22] Reimbursements from the California Department of Corrections and the California Youth Authority.

[23] Miscellaneous Reimbursements include patient-generated reimbursements.

[24] From FY 1985-86 through FY 1989-90, the DMH provided data. From FY 1990-91 to FY 1993-94, the CMHDA provide

Table 85: Realignment revenues from FY 1990-91 (General Fund Base) through FY 1994-95 (in thousands).

Fiscal Years	Local Revenues	Percent Change from Prior Year	Difference from Base	Percent Difference from Base
FY 1990-91 (Base)	$749,000[25]			
FY 1991-92	$668,009			
Difference: FY 1990-91 to FY 1991-92	($80,991)	-10.8%	($80,991)	-10.8%
FY 1992-93	$708,987			
Difference: FY 1991-92 to FY 1992-93	$40,978	6.1%	($40,013)	-5.3%
FY 1993-94	$709,314			
Difference: FY 1992-93 to FY 1993-94	$327	0.05%	($39,686)	-5.3%
FY 1994-95	$749,464			
Difference: FY 1993-94 to FY 1994-95	$40,150	5.7%	$464	0.1%

Source: Governors' Budgets

Table 86: Funds transferred to Mental Health Subaccount in FY 1991-92, FY 1992-93, and FY 1993-94.

	FY 1991-92			FY 1992-93	FY 1993-94
Region	From Health	From Social Services	Subtotal	From Health	From Health
Bay Area	$4,000,000	$0	$4,000,000	$4,200,000	$4,300,000
Central	$40,000	$63,000	$103,000		
Southern	$0	$459,000	$459,000	$1,583,000	$1,583,000
Superior	$78,000	$19,000	$96,000	$40,000	
Statewide	**$4,118,000**	**$541,000**	**$4,658,000**	**$5,823,000**	**$5,883,000**

Source: State Controller and Survey of Local Mental Health Departments

Table 87: Funds transferred out of Mental Health Subaccount in FY 1992-93 and FY 1993-94.

	FY 1992-93			FY 1993-94		
Region	To Health	To Social Services	Subtotal	To Health	To Social Services	Subtotal
Central	($404,000)	($2,001,000)	($2,405,000)	($1,349,000)	($2,010,000)	($3,359,000)
Southern	$0	($873,000)	($873,000)			
Superior	$0	($66,000)	($66,000)			
Statewide	**($404,000)**	**($2,940,000)**	**($3,344,000)**	**($1,349,000)**	**($2,010,000)**	**($3,359,000)**

Source: State Controller and Survey of Local Mental Health Departments

[25] This amount represents the funding from the General Fund that was to be replaced by sales tax revenue.

Table 88: Reasons for subaccount transfers to Mental Health Subaccount in FY 1991-92.

	Bay Area	Central	Southern	Superior	**Statewide**
The other subaccount had a surplus, and mental health had a deficit	$0	$63,000	$0	$78,000	**$141,000**
Transfers approved by governing body to maintain existing programs in all realigned areas	$0	$0	$459,000	$0	**$459,000**
Interagency agreement	$4,000,000	$0	$0	$0	**$4,000,000**
Unknown		$40,000	$0	$19,000	**$59,000**
Grand Total	**$4,000,000**	**$103,000**	**$459,000**	**$97,000**	**$4,659,000**

Source: Survey of Local Mental Health Departments

Table 89: Reasons for subaccount transfers out of Mental Health Subaccount in FY 1992-93.

	Region			
	Central	Southern	Superior	**Statewide**
The other subaccount could not fund all the service demand mandated by an entitlement program	($2,405,000)	($873,000)	($66,000)	**($3,344,000)**
Grand Total	**($2,405,000)**	**($873,000)**	**($66,000)**	**($3,344,000)**

Source: Survey of Local Mental Health Departments

Table 90: Reasons for subaccount transfers to Mental Health Subaccount in FY 1992-93.

	Region			
	Bay Area	Southern	Superior	**Statewide**
Other subaccount had a surplus and mental health had a deficit	$0	$0	$40,000	**$40,000**
Interagency agreement	$4,200,000	$1,583,000	$0	**$5,783,000**
Grand Total	**$4,200,000**	**$1,583,000**	**$40,000**	**$5,823,000**

Source: Survey of Local Mental Health Departments

Table 91: Reasons for subaccount transfers out of Mental Health Subaccount in FY 1993-94.

	Region	
	Central	**Statewide**
Other subaccount had deficit, and funding it was higher priority than mental health	($1,349,000)	**($1,349,000)**
Other subaccount could not fund all the service demand mandated by an entitlement program	($2,010,000)	**($2,010,000)**
Grand Total	**($3,359,000)**	**($3,359,000)**

Source: Survey of Local Mental Health Departments

Table 92: Reasons for subaccount transfers to Mental Health Subaccount in FY 1993-94.

	Region		
	Bay Area	Southern	**Statewide**
Interagency Agreement	$4,300,000	$1,583,000	**$5,883,000**
Grand Total	**$4,300,000**	**$1,583,000**	**$5,883,000**

Source: Survey of Local Mental Health Departments

APPENDIX 3

MHB/C IMPLEMENTATION OF STATUTORY DUTIES

Table 87: WIC 5604.2(a)(1)--Reviewing mental health needs for 1993.

	Bay Area		Central		Sout
	Number of Responses	Percent of Counties Responding	Number of Responses	Percent of Counties Responding	Number of Responses
Had presentations at MHB/C meetings	12	100.0%	11	84.6%	9
Reviewed facilities and services	9	75.0%	11	84.6%	9
Established committees	11	91.7%	9	69.2%	9
Submitted annual report to gov. body	8	66.7%	5	38.5%	7
Held public meetings	6	50.0%	3	23.1%	3
Helped select contractors	3	25.0%	6	46.2%	6
Applied for grants	1	8.3%	3	23.1%	1
Involved in planning process	1	8.3%	1	7.7%	0
Not done--MHB/C lacks experience	0	0.0%	1	7.7%	0
Not aware of this requirement	0	0.0%	0	0.0%	1
Grand Total	**51**		**50**		**45**

Number of Counties Responding	**12**		**13**		**10**

Source: Survey of Mental Health Boards/Commissions

Table 88: WIC 5604.2(a)(1)--Reviewing mental health needs for 1994.

	Bay Area		Central		Sout
	Number of Responses	Percent of Counties Responding	Number of Responses	Percent of Counties Responding	Number of Responses
Had presentations at MHB/C meetings	12	100.0%	13	92.9%	9
Reviewed facilities and services	9	75.0%	12	85.7%	7
Established committees	10	83.3%	10	71.4%	10
Submitted annual report to gov. body	7	58.3%	6	42.9%	8
Helped select contractors	6	50.0%	6	42.9%	7
Held public meetings	5	41.7%	4	28.6%	3
Applied for grants	1	8.3%	4	28.6%	1
Combatted stigma and discrimination	1	8.3%	0	0.0%	0
Involved in planning process	1	8.3%	0	0.0%	0
Not done--MHB/C lacks experience	0	0.0%	1	7.1%	0
Not aware of this requirement	0	0.0%	0	0.0%	1
Grand Total	**52**		**56**		**46**

Number of Counties Responding	**12**		**14**		**10**

Source: Survey of Mental Health Boards/Commissions

Table 95: WIC 5604.2(b)(1)--Assessing realignment for 1993.

	Bay Area		Central		Sout
	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Number of Counties
Completed assessment of realignment	3	25.0%	6	42.9%	5
No. Too early to assess realignment	6	50.0%	2	14.3%	2
Not aware of this requirement	0	0.0%	0	0.0%	1
New MHB/C members uninformed about realignment	0	0.0%	1	7.1%	0
Other projects had higher priority	0	0.0%	1	7.1%	0
No answer	3	25.0	4	28.6	2
Grand Total	**12**	**100.0%**	**14**	**100.0%**	**10**

Source: Survey of Mental Health Boards/Commissions

Table 96: WIC 5604.2(b)(1)--Assessing realignment for 1994.

	Bay Area		Central		Sout
	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Number of Counties
Completed assessment of realignment	5	41.7%	7	50.0%	6
Plan to assess realignment after 1994	1	8.3%	1	7.1%	0
MHB/C testified about realignment at CMHPC public hearing	1	8.3%	1	7.1%	0
Partial assessment completed	1	8.3%	0	0.0%	0
Continuing change in funding by State makes assessment too difficult	0	0.0%	1	7.1%	0
No. Too early to assess realignment	3	25.0%	1	7.1%	4
Have not completed assessment of realignment	0	0.0%	1	7.1%	0
New MHB/C members uninformed about realignment	0	0.0%	1	7.1%	0
Other projects had higher priority	1	8.3%	1	7.1%	0
Grand Total	**12**	**100.0%**	**14**	**100.0%**	**10**

Source: Survey of Mental Health Boards/Commissions

Table 97: WIC 5604.2 (a)(2)--Reviewing performance contracts for 1993.

	Bay Area		Central		Sout
	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Number of Counties
Reviewed performance contracts	12	100.0%	11	78.6%	10
Not yet, but plan to	0	0.0%	1	7.1%	0
Not aware of requirement	0	0.0%	1	7.1%	0
MHB/C not operating	0	0.0%	1	7.1%	0
Grand Total	**12**	**100.0%**	**14**	**100.0%**	**10**

Source: Survey of Mental Health Boards/Commissions

Table 98: WIC 5604.2(a)(2)--Reviewing performance contracts for 1994.

	Bay Area		Central		Sout
	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Number of Counties
Reviewed performance contracts	11	91.7%	11	78.6%	8
Not yet, but plan to	1	8.3%	2	14.3%	0
Not yet received it	0	0.0%	0	0.0%	2
Not aware of requirement	0	0.0%	1	7.1%	0
Grand Total	**12**	**100.0%**	**14**	**100.0%**	**10**

Source: Survey of Mental Health Boards/Commissions

Table 94: WIC 5604.2(a)(3)--Advising governing body and director for 1993.

	Bay Area		Central		Sout
	Number of Responses	Percent of Counties Responding	Number of Responses	Percent of Counties Responding	Number of Responses
MHB/C chair communicates with director	12	100.0%	11	78.6%	10
Advise director at monthly MHB/C meetings	11	91.7%	11	78.6%	10
MHB/C members communicate with director	9	75.0%	10	71.4%	10
Advise director at MHB/C executive committee meetings	9	75.0%	9	64.3%	8
Review and comment on director's written correspondence	8	66.7%	7	50.0%	6
Advise governing body in writing	11	91.7%	9	64.3%	10
MHB/C testifies at governing body meetings	11	91.7%	8	57.1%	9
MHB/C members communicate with county supervisors	10	83.3%	8	57.1%	9
Annual report to governing body	9	75.0%	4	28.6%	7
Review and approve mental health budget	0	0.0%	1	7.1%	0
Not aware of this requirement	0	0.0%	1	7.1%	0
Grand Total	**90**		**79**		**79**

Number of Counties Responding	**12**		**14**		**10**

Source: Survey of Mental Health Boards/Commissions

Table 95: WIC 5604.2(a)(3)--Advising governing body and director for 1994.

	Bay Area		Central		Sout
	Number of Responses	Percent of Counties Responding	Number of Responses	Percent of Counties Responding	Number of Responses
MHB/C chair communicates with director	12	100.0%	11	78.6%	10
Advise director at monthly MHB/C meetings	12	100.0%	12	85.7%	10
MHB/C members communicate with director	10	83.3%	11	78.6%	10
Advise director at MHB/C executive committee meetings	9	75.0%	10	71.4%	8
Review and comment on director's written correspondence	9	75.0%	8	57.1%	6
Advise governing body in writing	12	100.0%	9	64.3%	10
MHB/C members testify at governing body meetings	9	75.0%	9	64.3%	8
MHB/C members communicate with county supervisors	10	83.3%	10	71.4%	8
Annual report to governing body	7	58.3%	6	42.9%	8
Review and approve mental health budget	0	0.0%	1	7.1%	0
Not aware of this requirement	0	0.0%	1	7.1%	0
Grand Total	**90**		**88**		**78**

Number of Counties Responding	**12**		**14**		**10**

Source: Survey of Mental Health Boards/Commissions

Table 101: WIC 5604.2 (a)(4)--Ensuring involvement in planning for 1993.

	Bay Area		Central		S
	Number of Responses	Percent of Counties Responding	Number of Responses	Percent of Counties Responding	Number Respons
Through community input at MHB/C meetings	10	83.3%	11	84.6%	10
By conducting public hearings	7	58.3%	4	30.8%	2
Through membership on dept. committees	3	25.0%	1	7.7%	2
Involvement of AMI chapters	0	0.0%	1	7.7%	2
Review county's mental health planning mechanisms	1	8.3%	1	7.7%	0
Department does not provide opportunity to participate in planning	1	8.3%	0	0.0%	0
Not aware of this requirement	0	0.0%	2	15.4%	0
Grand Total	**22**		**20**		**16**
Number of Counties Responding	**12**		**13**		**10**

Source: Survey of Mental Health Boards/Commissions

Table 102: WIC 5604.2(a)(4)--Ensuring involvement in planning for 1994.

	Bay Area		Central		S
	Number of Responses	Percent of Counties Responding	Number of Responses	Percent of Counties Responding	Number Respons
Through community input at MHB/C meetings	11	91.7%	11	78.6%	10
By conducting public hearings	7	58.3%	5	35.7%	4
Through membership on dept. committees	4	33.3%	1	7.1%	2
Involvement of AMI chapters	0	0.0%	1	7.1%	1
Review county's mental health planning mechanisms	1	8.3%	1	7.1%	0
Department does not provide opportunity to participate in planning	1	8.3%	0	0.0%	0
Not aware of this requirement	0	0.0%	2	14.3%	0
Grand Total	**24**		**21**		**17**
Number of Counties Responding	**12**		**14**		**10**

Source: Survey of Mental Health Boards/Commissions

Table 99: WIC 5604.2(a)(5)--Submitting annual report to governing body for 1993.

	Bay Area		Central		Sout
	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Number of Counties
Submitted annual report	7	70.0%	4	44.4%	7
Not yet, but plan to	2	20.0%	0	0.0%	0
No. Other issues of higher priority	1	10.0%	2	22.2%	3
Not aware of this requirement	0	0.0%	2	22.2%	0
Not possible due to board restructuring	0	0.0%	1	11.1%	0
Grand Total	**10**	**100.0%**	**9**	**100.0%**	**10**

Source: Survey of Mental Health Boards/Commissions

Table 101: WIC 5604.2(a)(5)--Submitting annual report to governing body for 1994.

	Bay Area		Central		Sout
	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Number of Counties
Submitted annual report	3	27.3%	5	35.7%	2
Not yet, but plan to	6	54.5%	7	50.0%	8
No. Other issues of higher priority	1	9.1%	1	7.1%	0
Not aware of this requirement	0	0.0%	1	7.1%	0
Not possible due to board restructuring	0	0.0%	0	0.0%	0
Board is not capable of this project	1	9.1%	0	0.0%	0
Grand Total	**11**	**100.0%**	**14**	**100.0%**	**10**

Source: Survey of Mental Health Boards/Commissions

Table 105: WIC 5604.2(a)(6)--Participating in selecting mental health director in 1993.

	Bay Area		Central		Sout
	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Number of Counties
Participated in selecting director	4	33.3%	2	15.4%	1
Not applicable. No change in director	8	66.7%	9	69.2%	8
Only approved selection of director	0	0.0%	0	0.0%	1
MHB/C protested its exclusion from selection process	0	0.0%	1	7.7%	0
Not aware of this requirement	0	0.0%	1	7.7%	0
Grand Total	**12**	**100.0%**	**13**	**100.0%**	**10**

Source: Survey of Mental Health Boards/Commissions

Table 106: WIC 5604.2(a)(6)--Participating in selecting mental health director in 1994.

	Bay Area		Central		Sout
	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Number of Counties
Participated in selecting director	4	33.3%	4	28.6%	0
Not applicable. No change in director	8	66.7%	7	50.0%	9
Only approved selection of director	0	0.0%	1	7.1%	1
Not aware of this requirement	0	0.0%	2	14.3%	0
Grand Total	**12**	**100.0%**	**14**	**100.0%**	**10**

Source: Survey of Mental Health Boards/Commissions

Table 107: Additional duties transferred to MHB/Cs by governing bodies.

	Bay Area		Central		Sout
	Number of Counties	Percent of Counties	Number of Counties	Percent of Counties	Number of Counties
None	11	91.7%	13	92.9%	10
Reviewing major mental health contracts	0	0.0%	1	7.1%	0
Reviewing procedures for community involvement in developing the budget	1	8.3%	0	0.0%	0
Advising on selection of professionally licensed staff	0	0.0%	0	0.0%	0
Grand Total	**12**	**100.0%**	**14**	**100.0%**	**10**

Source: Survey of Mental Health Boards/Commissions

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